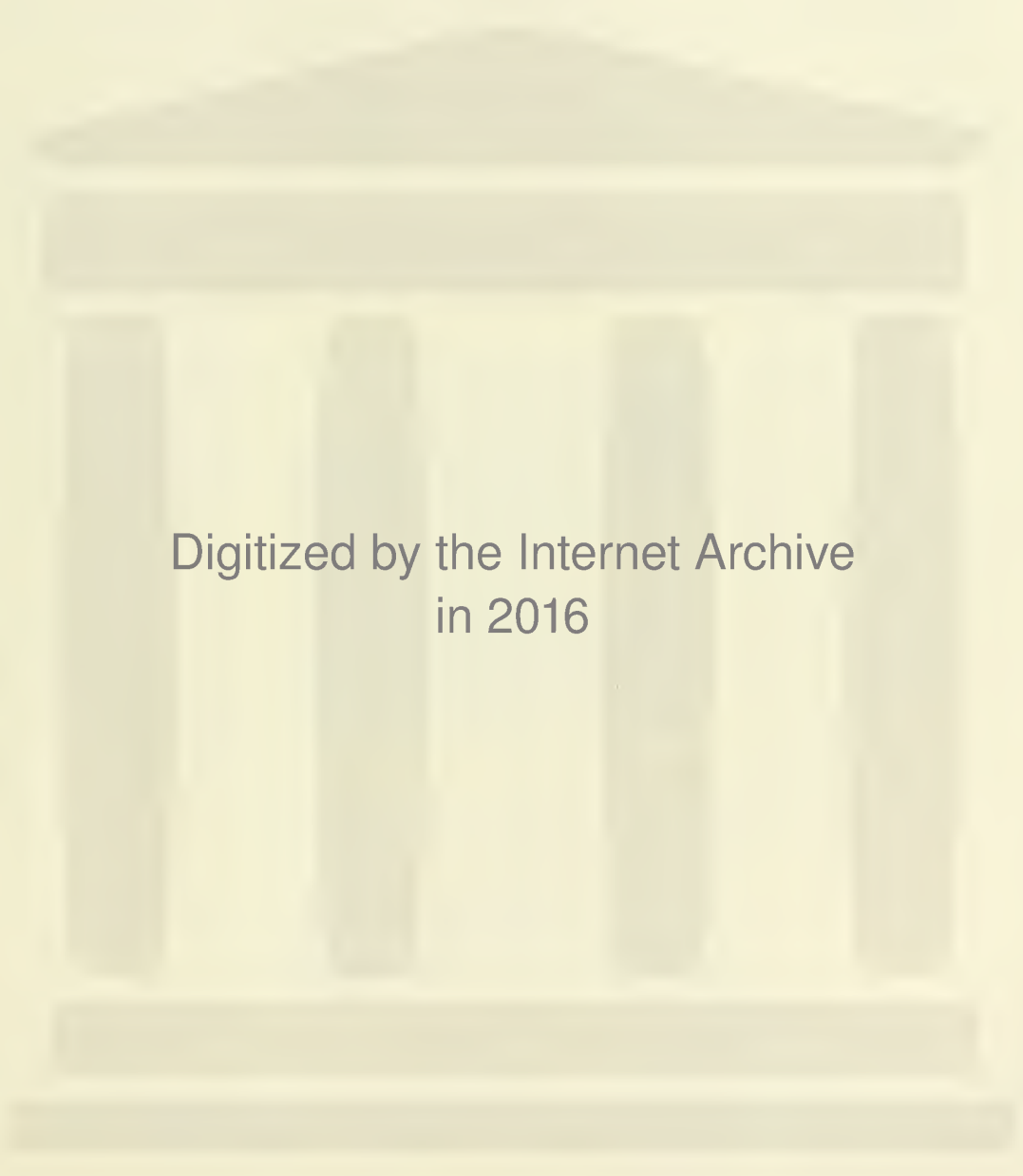
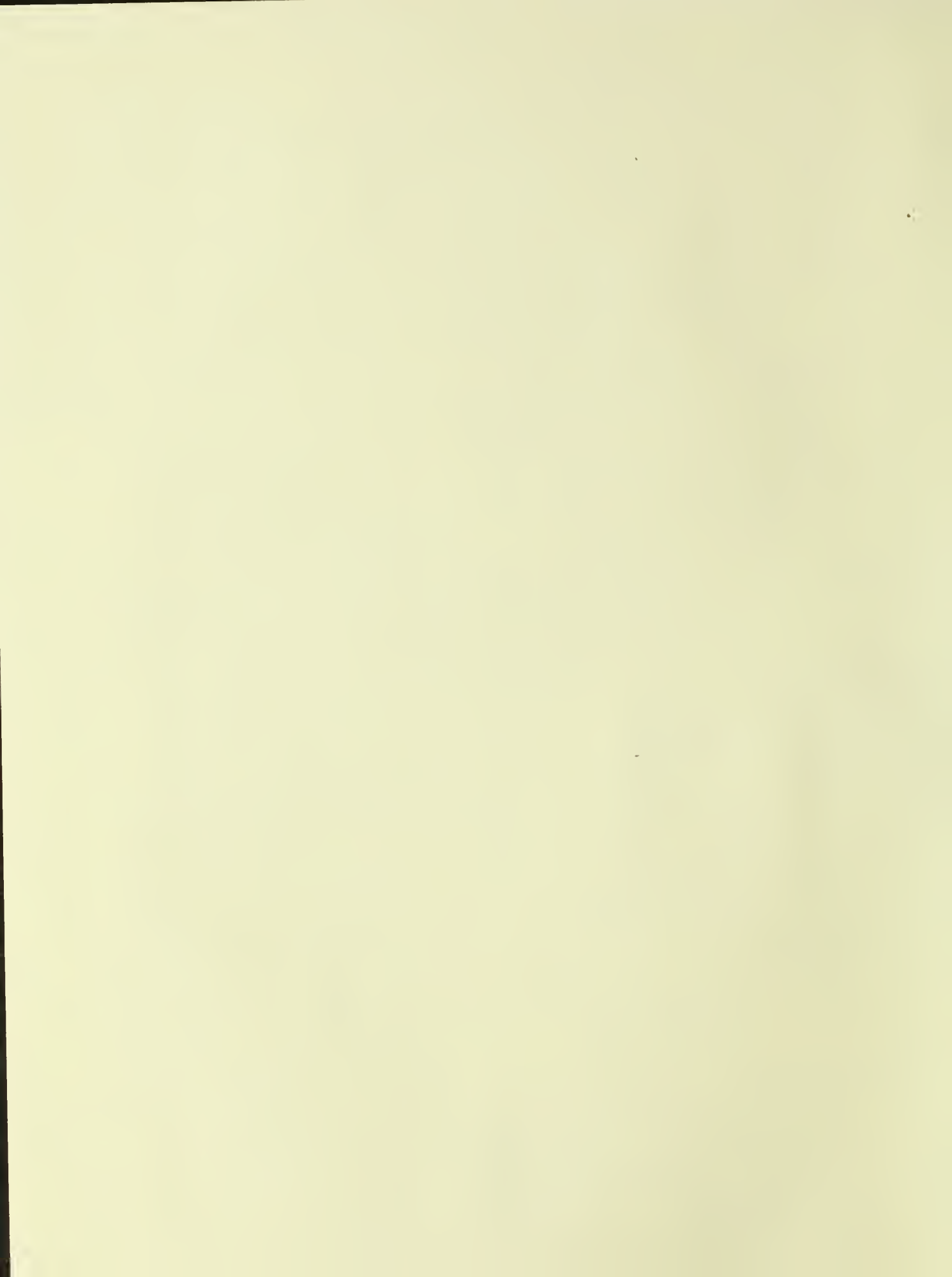


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OHIO Medicine

JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

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JANUARY 1991

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Rural Communities Scrambling for Doctors

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Happy New Year!

Let's start the New Year with a positive note. It seems we have to look long and hard for something to be happy about — after that budget-reconciliation fiasco — but small steps are helpful.

Your efforts and contacts with Congress got the anti-hassle bill passed — the section regarding publicizing the “screens” did not pass. Agree with the passing or

not, the anti-competitive reason used to reject it has some logic.

You really did it in a storm of 50,000 letters that descended on Washington, protesting and pointing out the senselessness,

impracticality and increased expense of the proposed office laboratory regulations. The whole proposal has been withdrawn because you let our representatives know, in no uncertain terms, that it just wouldn't work. Even the sponsor of the initial legislation got on the bandwagon, stating that the proposal was fantastic overkill to the problem (actually directed at Pap smear interpretation). It will be at least September before the new regulations are published. Stay tuned.

Congratulations, also, to Nino

Camardese, MD, who recently won the case on Medicare billing of office laboratory procedures. The Federal Appeals Court has refused to reverse the decision of the lower court. Nino has also been nominated for the Benjamin Rush award of the AMA. There is certainly no question that he is willing to put his money where his mouth is, and there is no question of his devotion to God, country and medicine.

It is encouraging to see that the governor's Task Force has come up with a plan (Access Ohio) for financing the health-care needs of Ohioans. The plan bears striking congruity with Health Access America, but even more interesting, I thought, were Gov. Celeste's remarks in accepting the report. He stated that this problem cannot be solved by state action alone, but must be a conjoint effort of business, the professionals and government — that from a man who fancies himself to be a political philosopher. That is as realistic thinking as we'll get.

The process of dialogue takes effort. Many of the provisions of Health Access America have been introduced in Congress and will be back next session. Bill 3042 (Coburn, R-Maine), “Comprehensive Health-Care Act of 1990,” contains a variety of provisions — payment for physicians and hospitals, favorable tax treatment of health insurance experts, long-term care insurance, uninsurable risk pools, Medicaid standardization expansion and

**By John A.
Devany, MD**

**President of
the OSMA**



Presidential Perspectives

medical liability reform (all are in Health Access America).

The medical liability provisions unfortunately do not have any effect on our problem in Ohio with the statute of limitations, but they do put great emphasis on the development of treatment practice parameters (TPGs). Am I alone when I get a slight chill listening to talk of specifying appropriate-inappropriate and permissive methods of evaluation and treatment? All of us want to be current — but think of some of the ideas that were current 25 years ago (e.g. carotid body surgery). However, the anesthesiologists and the OB-GYN group has demonstrated that protocols do have a place — and they successfully affected their malpractice rates by following them. The idea being that TPGs establish a rebillable prescription that the services prescribed by the TPGs are the appropriate standard of care. Peer review organizations could use these parameters in making payment determination (screens again).

Most of you have heard me rave about the persistent deprofessionalization of medicine — which can be attributed to the government, notably the Federal Trade Commission, and to the insurance industry. But let us not let our friends in hospital administration off the hook too early. We must each remember that hospitals are a business — they don't forget it. We now hear at meetings of "economic credentialing" becoming a basis for hospital privileges. A recent study reported in *AMNews* says that a review of how a physician uses a hospital's service can affect the hospital's bottom line is now in place. As Ray Gifford, MD, has pointed out, that concept has two different factors:

1. Does a physician generate profit by bringing in an economically favorable patient mix?

2. Does individual utilization review illustrate financial and/or quality of care issues — which cause the hospital to lose money?

All of the bowing and scraping that I see with hospitals courting physicians with physician staff counselors who function as a concierge is as phony as a \$3 bill. "Everything is just so great at Better Samaritan Hospital!"

Physicians must be aware that there is a Medicare regulation against rebates between physicians and between hospitals and physicians. (We are not providers.)

The FTC is reported to be evaluating office space contracts between hospitals and doctors to see what "sweetheart" provisions amount to rebates. So check the market, check with your attorney and remember that there are wolves out in those woods.

There is good reason in today's climate to feel that we have lost the ability to affect our own destiny, so we must cut the best deal for ourselves. This is no time to go it alone. The next two to five years will demand an intelligent look at professional militancy.

The picture is not all dark. When we stand together as doctors, we can be heard! **OSMA**

ATTENTION RESIDENTS AND MEDICAL STUDENTS!

OHIO Medicine invites you to enter our second "Medical Writing Contest."

The competition is open only to Ohio medical residents and students. A plaque and a \$250 prize will be awarded to both a resident and a medical student who submit the most outstanding scientific paper as judged by a distinguished panel of medical experts.

The papers should be submitted between now and March 1, 1991. Winners will be announced and prizes awarded at the 1991 OSMA Annual Meeting in Columbus, Ohio.

The winning entries will also be published in *OHIO Medicine*.

All entries should be no more than 10 typed, double-spaced pages in length, and should be sent to:

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A Brighter Future Starts Now

Physicians and auxiliaries have a strong tradition of service to medical schools and medical students through their contributions to AMA-ERF — The American Medical Association Education and Research Foundation.

Last year, auxiliaries across this nation provided over \$2 million in

funds to medical schools for use in their general excellence funds or for medical assistance funds for students.

Ohio increased its giving by almost \$5,000 — from \$58,993

to \$63,505. This was a giant leap and required a great deal of hard work by the AMA-ERF committees — county- and statewide. We congratulate them.

Now it is time to concentrate our efforts to see that that level of giving is maintained and — we hope — exceeded for the 1990-91 year. This is our opportunity to ensure the future of medicine by providing funds to see that medical students are the brightest and most talented, and that the quality of their medical training is the very

best possible.

The Ohio State University, University of Cincinnati, Wright State University, Case Western Reserve, Northeastern Ohio College of Medicine, and Medical College of Ohio all receive funds from the efforts of Ohio physicians and auxiliaries. Donors specify the school or schools of their choice when making their AMA-ERF contributions as well as the fund to which they want their donation to be credited.

Manuel Tzagournis, MD, dean of the College of Medicine at The Ohio State University, wrote that these funds “make the difference between having a highly successful program or simply pursuing the routine curriculum.” Arthur W. Brodeur, director of The Ohio State University Campaign, stated that “Philanthropy such as this helps to enhance the excellence within which Ohio State can provide a level of teaching, research, treatment and public service equal to any in the world.” The deans of all Ohio medical schools have acknowledged the AMA-ERF contributions and their value to their respective schools. Student and faculty assistance appears to be a major need at all of these institutions.

Quality education is essential if we are to retain the high level of skill and professionalism that the medical profession has always insisted upon. That quality

Continued on page 8

By Sue Massie

**OSMA Auxiliary
President**



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I understand an invitation has been extended to the legislators by Sue Massie, OSMA-A President, and the OSMA Legislative Committee, but I will personally contact my Senator/State Representative to attend.

Senator/Representative: _____

Keeping the Dream Alive

In order to understand how a practicing physician might play a critical role in facilitating Dr. Martin Luther King's dream of equality for all, I think it's important to review the special

position that I believe physicians hold in our society.

While it is true that the image of the practicing physician has come down a rung or two in recent years,

physicians are still, generally, held in high esteem.

A physician is, first and foremost, a potential healer for the patient who is suffering from pain, frightened by the possibility of disease, or emotionally distraught. Thus, a doctor often has the opportunity to intervene at a unique moment in another person's life. The power of the doctor-patient relationship is enormous because it represents an opportunity for a physician to provide help at times when the patient is most vulnerable. First, of course, that help must be provided by a competent, knowledgeable individual applying great skill, but

equally important is the ability of the doctor to connect with each patient in a special, almost ineffable way.

Let me share with you an example that might illustrate this concept. One of our medical students a number of years ago was part of a hospital team that I was supervising. One day, the team admitted to the Critical Care Unit an 85-year-old woman who appeared in much distress. The interns, residents, family and myself could neither get the woman to calm down, nor to cooperate and take the necessary medications. She was considered by us otherwise to be competent, and therefore, we could not force her to take any medication. After several failed attempts to determine the cause of her anger, it was decided to leave her alone, but not unattended, for awhile.

I happened to be making rounds on my own later that afternoon, and saw one of our students in the room talking easily with the patient. He did not see me looking at him through the transparent glass doors, but what I noticed was most intriguing. He was stroking her forearm gently and caringly as he spoke. The nonverbal communication was striking. This student was clearly connecting with the patient. I asked that student later that day

**By Kim
Goldenberg, MD**



Second Opinion

how he was able to communicate with this particular patient when no one else had been able to do so. His response was at once both profound and inspiring, though he did not mean it to be either. He said, "Although this elderly woman comes from a different culture than I do, I was able to relate to her fear of being in the hospital, for she and I, after all, are made from the same basic stuff."

Retrospectively, this response is not unlike what Dr. King might have eluded to when he said "We see men as Jews or Gentiles, Catholics or Protestants, Chinese or Americans, Negroes or Whites. We fail to think of them as fellow human beings, made from the same basic stuff as we, molded to the same divine image." Historians have used this quote to demonstrate Dr. King as a champion of the freedom and dignity of the individual. Should less noble behavior be expected of physicians who often intervene at the most critical times in a patient's life, when the loss of freedom and dignity are at greatest risk? Although an appreciation of the dignity of each individual is paramount in relating to patients, Dr. King's dream might suggest an expanded role for the physician.

Again I quote Dr. King: "Decisions (are) issued from a self that has been formed by nature and history. The self includes: bodily structures, psychic strivings, morale and spiritual character, communal relations, past experiences (both remembered and forgotten), and the total impact of the environment." Again, historians have used this quote to reflect on Dr. King's need to understand an individual's background in order to perceive that person's views within a "life context." It is well-known and not surprising that the physician who

communicates with a patient and hopes to help that patient in periods of greatest need comes to understand that individual's background and cultural perspective through which that person acts, reacts and forms decisions.

Can seeing the patient's perspective and feeling the patient's concern be completely accomplished without an appreciation or contemplation of what it might be like to be in that person's position? Perhaps an old Spanish proverb sums it up well: "The appearance of the bull changes as one leaves the grandstand and enters the ring." Without any doubt, Dr. King did not hesitate to leave the grandstand and enter the ring. In front of this nation's capital, to an audience of over a quarter of a million people, he so eloquently noted that his dream was deeply rooted in the "American Dream"

of equality and understanding.

In the citation of the Presidential Medal of Freedom to Dr. King, it is stated, "He helped us overcome our ignorance of one another." The implication of Dr. King's dream for physicians, therefore, is really no different than for all of us; only that physicians are uniquely situated in position, esteem and during critical periods in a patient's life, to especially facilitate that something noble in humanity that permeated his dream. **OSMA**

*Kim Goldenberg, MD, is dean of Wright State University's School of Medicine in Dayton. This piece was originally presented by Dr. Goldenberg at a medical school ceremony honoring the life of Dr. Martin Luther King, Jr. It was subsequently published in **Dayton Medicine**, from which **OHIO Medicine** has reprinted this article.*

Auxiliary Page . . . continued

education has become cost prohibitive to many bright and promising young adults. AMA-ERF can provide the means by which we can help those who have the potential for greatness in medicine to reach that potential.

Others were there to provide needed assistance when you physicians were in medical school, and now *it is your turn!*

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AMA-ERF. She will process your check and see that your funds are directed to the medical school(s) of your choice and that you receive proper acknowledgement. Help the Auxiliary secure the future of medicine. Send your check made payable to AMA-ERF to 1500 Lake Shore Drive, Columbus, Ohio 43204. Be sure to designate the medical school and fund to which you would like your donation credited. It will be a great way to start your new year. Happy New Year! **OSMA**



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Ohio Medi-Scene

A closer look at Ohio's migrating "snow birds"

This time of year, it's not unusual for cars with Ohio license plates to be spotted on roads heading south, their occupants in search of warmer, sunnier climates.

Many of them are seeking only a respite from Ohio's inclement winter weather, but for over a decade increasing numbers of elderly Ohioans have migrated to the nation's sunbelt area in search of permanent homes. In 1970, for example, about 53,000 Ohioans, age 60 and over, left for warmer locations. By 1980, 86,000 Ohioans were making the trip, 44% of them to Florida, 8% to California.

Most of these migrating seniors are in good health when they embark for their new locations, but what happens when illness, or their advancing age, catches up with them? Is making such an abrupt change in lifestyle, moving away from family, friends and a health-care system they have grown accustomed to, such a good idea so late in life?

Those are the questions being asked by Case Western Reserve University sociologist Eva Kahana in a pioneering project, spun off of a 1984 study she conducted, in which 150 people in their 60s and early 70s, who had just moved to Florida, were asked how stressful the move had been.

The majority had indicated at that time that they were satisfied with their lives, and had not yet missed their home, communities, or those they left behind.

This earlier research turned up a surprise, as well — the elderly's reasons for migration.

Most gerontologists think that when the elderly do things, they do them for practical reasons, says Kahana. For example, they may move because their doctors recommended the warmer climate

for their health, or because their money may go farther in Florida.

"This is one of the stereotypes of aging," Kahana says. "In our earlier research, we found many older people just wanted to do something different, and be adventuresome. I think there is an optimistic message here that, even after retirement, there can still be a new beginning. Instead of thinking, I will be stuck living in cold weather, or in the same place I lived all my life, that my friends are dying off, and I am all alone, more elderly people will realize they have the option to relocate."

Of course, the question that remains is whether those findings continue as they grow older — the focus of the new project.

"Our expectations are that the

more social support you receive from friends and neighbors, the more it will ease the burdens of maintaining yourself independently," says Kahana.

The National Institute of Aging awarded CWRU \$675,000 for the first five years of the new study. Research, however, is expected to continue for eight years.

"We should not make the inference that relocation to the Sun Belt is good for people, period," says Kahana. "It may be that in the short run, it works out very positively, but once they become frail, they would be missing the natural supports of the family.

Although neighbors and friends in the new community may take on the role of family members,



Ohio Medi-Scene

Kahana cautions: "We don't know the extent to which elderly people can make deep friendships late in life. We're going to be looking in depth at that — how friends and neighbors help one another.

The new study, which began last February, is tracking 800 people over age 75 who moved from Northern cities to a Clearwater, Florida retirement community. Residents are asked about lifestyle; mental and physical health; long-distance communications with family and friends; and to what extent paid helpers or agencies are used to get groceries, clean houses, do yardwork, or help them meet appointments.

"We think the results would help health-care professionals to see what the needs of old people are who have relocated, and to counsel people as they plan relocation," Kahana says.

The research also may determine the fate of "empty nesters" — how parents will manage when their children move away from them.

"In the past," says Kahana, "researchers have looked at the sick, the poor, and elderly people with problems, so a lot of what we learn about old age is based on this." However, she adds, "We may be developing a false picture about late life. Knowledge then gets translated into public policy; whatever we believe to be true of the elderly is the way we treat them." **OSMA**

Tax deductions for migrating elderly

If you have advised a patient to move south, or elsewhere, for medical reasons, the costs for changing locations, based upon that advice, *can* mean a tax deduction for that patient, regardless of the suddenness or

chronic nature of the illness . . . but not always.

For example, the cost of transportation, primarily for medical care, is deductible, but when the transportation cost is related to a medically motivated permanent move, the result may be quite different.

In a recent revenue ruling, reported in *Crain's Cleveland Business*, the IRS specifically ruled that the costs of selling one's home and moving to a new one may not always be deducted as a medical expense.

The ruling involved a patient who suffered from pulmonary fibrosis. The doctor advised him that air pollution where he lived adversely affected his condition, and that a 25% reduction in pollution would greatly benefit the patient, and might even provide a relief to his chronic condition.

The patient and his wife sold what they had planned to be their retirement home and built a new one in another part of the country with less pollen and pollution.

After the move, the condition of the patient greatly improved. The patient wanted to deduct the cost of selling the old home and searching for the new one as a medical expense. However, the IRS ruled to the contrary, stating that the move had not been prescribed by a doctor as part of a specific plan of medical care.

To be deductible, the IRS continued, the cost must be for goods or services directly related to the diagnosis, cure, mitigation, treatment or prevention of a disease or illness.

If you recommend a similar move to your patient, and your patient wishes to receive a deduction for the change in location, it's important that you document the recommendation as well as a specific plan of care. Further, make certain that you relate the treatment to some specific illness or malady of the patient.

Of course, while revenue rulings are the official opinion of the IRS, the Tax Court or some other court considering the same facts and circumstances could see things differently. And, ultimately, whether or not your patient receives a tax deduction for the move is up to your patient, his or her tax adviser, and the IRS. **OSMA**

Book keeps docs in stitches

Los Angeles medical reporter Don Herbert is currently looking for humorous anecdotes to include in his book, "Keeping Your Doctor in Stitches."

The work, still in progress, needs true, humorous incidents that have occurred in your practice.

In the author's own words: "This book is designed to show the funny side of medicine. It will deal with those situations you have all experienced in which the words or actions of patients and colleagues have left you limp with laughter. These stories have taken place in the hospital, in your office, or any other place where the healing arts are practiced. My book will cover all medical specialties."

Patients will be kept anonymous and doctors and nurses may also remain nameless, if they choose.

"Initial reaction to this book has been extremely positive from physicians all across the country," Herbert says. (His project was reported in the April 20, 1990 issue of *AMNews*.) "I would like to be able to include stories from your state."

If you wish to submit stories, please include your name, address, medical specialty and hospital affiliations and send them to: Don Herbert, 12327 Erwin Street, North Hollywood, California 91606. Or call (818) 980-0458. **OSMA**

Ohio Medi-Scene

Washington Fly-in

Physicians, auxiliaries and members of the OSMA staff gather in front of the Capitol during a one-day fly-in trip to Washington, D.C. to meet with legislators.

The meeting, which was held in September, was co-sponsored by the OSMA and the Columbus Academy of Medicine. Chalmers Wylie (bottom right), a U.S. representative from Columbus and a senior member of the Ohio congressional delegation, arranged for the special photo to be taken.



Substance-sniffing deaths may be on rise

Beware the substance-sniffing adolescent. Recent reports in Cincinnati newspapers claim that a "mini-epidemic" of youths, sniffing everything from typewriter correction fluid to propane gas, is sweeping the city. Two boys died within months of each other after sniffing potentially lethal substances, and at least 16 other youths have met similar deaths since 1982.

Others, the papers report, have been hurt psychologically or physically (though not fatally) by sniffing substances that produce highs of varying degrees and duration.

"It seems there are more of these (sniffing fatalities) occurring in Cincinnati than elsewhere around the country," Earl Siegel, MD, associate director of the Drug and Poison Information Center at the University of Cincinnati, was quoted as saying. "It's like a mini-epidemic in this community."

An editorial that ran following news accounts guessed that the

incidents may be attributed to Cincinnati's strict adherence to laws prohibiting alcohol sales to minors.

"Alcohol, to be sure, remains a problem with minors," the editorial read. "But many may sniff potentially toxic substances that anyone can buy legally."

The editorial suggests that the dangers of sniffing such substances should be made clearer through warnings on labels and through cautions expressed by families, school officials and, one might add, the medical community. OSMA

Ohio Medi-Scene

OSMA produces sports videotapes

The OSMA has co-sponsored production and distribution of a 10-minute videotape on the need for protective mouthguards by athletes participating in interscholastic collision and contact sports. Currently, mouthguards are required only in football.

Copies of "Giving Your Mouth a Sporting Chance" have been sent to the 816 member schools of the Ohio High School Athletic Association. The videotape is narrated by nationally known sportscaster Ray Scott, and includes an appearance by former Boston Celtic/OSU basketball player John Havlicek. Produced by the Council on Health Information, based in Columbus, the videotape is also co-sponsored by the Ohio Dental Association and the Ohio Osteopathic Association.

Physicians interested in purchasing a copy should contact Suzanne Payne, Ohio Dental Association, 1371 Dublin Road, Columbus, OH 43215, (614) 486-2700. The cost is \$10 per copy.

Presently, physician-members of the Allen County Medical Society are developing another sports videotape on the dangers of anabolic steroids, which are used by an increasing number of professional, as well as student athletes.

The physicians are producing the video themselves, and hope to have it available for distribution soon. **OSMA**



Sen. David Hobson

Senator Hobson receives AMA award

The American Medical Association recently named Ohio State Senator David L. Hobson (R-Springfield) as one of eight recipients of its 1990 Nathan Davis Awards for contributions by public officials to advance health care. Sen. Hobson was nominated by the OSMA.

The awards recognize major achievements in "the art and science of medicine and the betterment of public health" by elected and career public officials in national, state and local governments. The awards are named for Nathan Davis, MD, founder of the AMA and first editor of its *Journal of the American Medical Association*.

Sen. Hobson, President Pro-Tempore of the Ohio Senate, was the only state legislator in the country to receive the award. He was cited for his efforts to educate Ohioans about AIDS, Alzheimer's disease, Parkinson's disease, and other disorders.

Sen. Hobson has long been

active in promoting public awareness of health issues. One of his most significant accomplishments was serving as chair of the Senate-House Task Force on AIDS, which helped pass one of the most comprehensive AIDS laws in the country. He has also advocated passage of legislation establishing health-care demonstration projects for uninsured workers. **OSMA**

Ohio health-care organizations win Innovators awards

Four Ohio health-care organizations — two in Columbus, one in Cleveland and one in Toledo — were awarded top honors for their innovative approaches in the delivery of health-care in the Healthcare Forum/3M Organizational Innovators Awards, a national competition.

University Hospitals of Cleveland won a gold medal in the multi-hospital system/alternative health-care provider category. Winner of the silver medal in the same category was Riverside Methodist Hospitals, Columbus, with Northwest Physicians, Inc., Toledo, winning the bronze medal.

Children's Hospital, Columbus, won the gold medal in the hospital/medical center 300 beds and over category.

University Hospitals of Cleveland

Over the past three years, University Hospitals of Cleveland reduced hospital expenses by more than \$32 million. One effort employed was the creation of three primary care units, for lower intensity patients. By lowering

Continued on page 15

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Am Fam Phys 1987;36:133-140

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Contraindication: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Cecilor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of non-susceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Cecilor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Cecilor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions have been reported with the use of Cecilor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, serum-sickness-like reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Cecilor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
- Stevens-Johnson syndrome, toxic epidermal necrolysis,

and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.

- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonía, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology.

- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Cecilor and Coumadin concomitantly.
- Abnormal urinalysis; elevations in BUN or serum creatinine.
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Ohio Medi-Scene

staffing requirements, room and board charges in these units were cut by 26%-43%.

Another creative method of identifying cost savings at University Hospitals took place at the "micro" level. To develop a model that could be applied throughout the industry, a team of management, nursing and medical staff selected one surgical procedure, in this case major joint replacements, to be studied in minute detail. They found that by making small changes in many aspects of treatment and follow-up care, the cumulative result was a decline of three days for hospital stays, and a 23% decrease in average charges.

Children's Hospital, Columbus

A second Ohio gold medal winner, Children's Hospital, Columbus, has devoted itself to developing strong relationships with area practitioners. The result is that 85% of all inpatient pediatrics in the Columbus area is done at Children's, making it one of the largest and most comprehensive pediatric hospitals in the nation.

New approaches to enhancing this collaboration have received national attention. For example, Children's Practicing Pediatricians provides support services to pediatrician members, including group purchasing of medical supplies for physicians' offices. This has proven to be so successful that Columbus pediatricians have consulted with physicians from around the country, and currently are purchasing supplies for 450 physician offices in three states.

Riverside Methodist Hospitals, Columbus

Another Columbus entry in the competition, Riverside Methodist Hospitals, won a silver medal for



Riverside Methodist Hospital won a silver medal for its public service television program.

its national public service television program, "Life Choices." The program features accurate, credible information on current health-care topics. The hospital was also acknowledged for its efforts to involve staff in community activities and its joint partnerships with the community to improve health opportunities for local residents.

Northwest Physicians

Northwest Physicians, Inc., an independent physician association in Toledo, won a bronze medal for its work in initiating creative physician incentives, one based on cost of care comparisons with peer physicians, to improve quality of care while managing costs. A second managed care innovation uses a focused health-care analysis to identify the area of cost excesses, thus allowing direct remedial action to control and lower costs.

Northwest Physicians' Prenatal

Care/Diaper Recognition program reduces neonatal expenditures by improving prenatal care for low-income mothers. A free, six-month supply of diapers was the incentive used to encourage mothers to complete 12 prenatal physician visits to prevent low birth weight and prenatal problems.

In addition to the Ohio medal winners, a merit award in the hospital/medical center 300 beds and over category went to the Toledo Hospital, Toledo. **OSMA**

Ohio Medi-Scene

NASA, Case Western work together to benefit orthopedics

NASA Lewis Research Center scientists and Case Western Reserve University medical specialists

and scientists are working together to increase the life of surgically replaced human joints by providing the capability to custom design prosthetic joint implants.

The objective of the program is to develop a computer code to

design orthopedic implants to provide a custom fit of the prosthetic joint for each patient to ensure a prosthetic joint life span of some 20 years and a corresponding minimum of discomfort to the patient. Using today's orthopedic procedures, a prosthetic joint may provide a serviceable life of as little as four years, with an average life of about seven years.

Today's orthopedic joint replacement practice is to fit the patient to the prosthesis rather than, ideally, fitting the prosthesis to the patient. However, by using computer programs developed for aerospace technology and modified for prosthesis design, the prosthesis will be able to be designed for each patient. With an optimally designed fit, the patient's weight and joint movements would be more evenly distributed on the supporting bone, which would eliminate bone deterioration and prosthesis loosening.

NASA Lewis Research Center is providing expertise in computational mechanics and CWRU is providing expertise in the area of orthopedic biomechanics. Pertinent areas under study include implant material and bone/tissue compatibility; correct implant placement and alignment; joint configuration and implant mating surfaces; joint mobility; joint durability; preservation of bone in and near the implant regions; and minimization of discomfort and cost to the patient.

According to Dr. Christos Chamis, senior aerospace scientist in the Lewis Research Center's Structures Division: "Our approach focuses on assembling many structural analyses and design modules along with defining the problem parameters to produce a computer code for optimizing prosthetic knee joints. After the study for knee joints is complete, we will begin studies for other prosthetic body joints." **OSMA**

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Ohio Medi-Scene

Physician Effectiveness Program to hire full-time director

The OSMA Physician Effectiveness Program (PEP) expects to hire a full-time medical director and staff in early 1991 for outreach to impaired physicians throughout Ohio.

In addition to the medical director and secretary, who will be based in the Academy of Medicine of Columbus and Franklin County offices in Dublin, two associate directors with masters level training and extensive experience in addictionology will be based in the offices of the Cincinnati Academy of Medicine and Academy of Medicine of Cleveland.

Since 1975, PEP has operated as a statewide network of physician volunteers, coordinated by Robert Clinger, OSMA's director of Medical Society and Member Relations.

According to Clinger, however, PEP Chair Edward Carden, MD, Cleveland and his committee have been eager to bring a full-time director on board for the last six years.

"Until now, anything that we've been able to do has been piecemeal," he says.

Dr. Carden, reflecting on his experience as the chair of the New Jersey Medical Society's impairment program when it became the first in the country to hire a full-time medical director in 1982, laments the committee's inability, thus far, to reach more impaired physicians and to channel them through treatment because of the limitations of its volunteer structure.

"We noticed the difference a full-time medical director made in New Jersey's program," Dr. Carden says. "Before we were able to hire specialized staff, impaired physicians were falling through the cracks. We couldn't get to them

fast enough, and we couldn't effectively communicate with the (state licensing) board on their behalf because we were volunteers, with limited time commitments."

With the new personnel, however, PEP expects to launch an organized, educational effort that will enable it to reach more impaired physicians.

"This educational effort will be the new director's top priority," adds Clinger.

In order to accomplish this goal, PEP's professional staff will establish links with county medical societies, specialty societies, medical schools, residency programs, hospital medical staffs and administration, auxiliary and the Ohio State Medical Board to teach others how to recognize impairment and deal with it effectively by referring physicians suspected of impairment to the PEP, where they will be handled with advocacy and confidentiality.

Certainly, if one were to compare the figures of impaired physicians helped by OSMA's PEP in recent years with those helped in New Jersey, the results would be revealing. In Ohio, the PEP committee processes about 25 cases a year, of which only half are suffering true impairment. New Jersey's figures have been consistently higher, however, averaging between 60 and 75 cases of impairment per year, despite a population that is only 2/3's that of Ohio's.

Part of the reason that more impaired physicians are discovered with a full-time director in place is that spouses, colleagues and others respond to the effectiveness and confidentiality of this approach.

"The people closest to the impaired physician aren't going to report the physician to the board early in the disease process," says Dr. Carden. "However, they may report the physician to the system that has a high profile of advocacy."

Obviously, the earlier impaired physicians can be treated, the lighter the case load of the Ohio State Medical Board.

Says Clinger: "That will definitely be another goal of the staff, to work closely with the Board and attempt to channel as many impaired physicians as possible through therapeutic measures rather than letting them reach the point where they must be reported to the Board."

As far as PEP and its new staff are concerned, "impairment" includes those physicians impaired by problems other than substance abuse.

According to Dr. Carden, New Jersey's impairment statistics consistently reveal that 70% of those in the system suffer from chemical addictions; 20%-22% from psychiatric problems; and 8%-10% from senility, or other physical impairments.

"Until these statistics were kept, many of us believed that chemical abuse would be as high as 90%. We vastly understand the frequency of psychiatric problems that were out there."

Consequently, any impairment cases that fall under the DSM III-R or DSM-IV when published will now be handled by the committee.

Since the majority of the PEP committee is presently addictionologists, we are currently working with the Ohio Psychiatric Association to establish a stronger, broader network of psychiatrists who will be able to help us with these other cases.

The hiring of full-time staff is just the beginning for the Physician Effectiveness Program, however. It is presently in the process of drawing up a model "after-care" contract that will ensure care and monitoring after treatment — again, an activity that had been handled piecemeal until now.

Continued on page 33

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Cleveland Initiates “Buy Right” Plan

- The Cleveland initiative is the latest effort made by businesses around the country to purchase high-quality health care at lower cost.



By 1992, hospitals in Cleveland will begin reporting uniform, clinical outcome and patient satisfaction data to business purchasers in what some are calling the most promising application of the “buy

right” approach to corporate health-care purchases.

The unprecedented agreement was reached late last year between Cleveland hospitals and physicians and the business community, which initiated the program in an attempt to enable companies to steer their workers toward better (not just cheaper) health care.

Among those participating in the program are the Greater Cleveland Hospital Association; the Academy of Medicine of Cleveland; and many of the area’s biggest employers, through the

Health Action Council of Northeast Ohio. Combined, these groups form the Greater Cleveland Health Quality Choice Coalition.

The Cleveland initiative is the latest effort made by businesses around the country to purchase high-quality health care at lower cost, an effort that falls under the “buy right” approach to corporate health-care purchases, popularized by Walter McClure, head of the Minneapolis-based health-care think tank known as the Center for Policy Studies. The “buy right” concept gives purchasers performance data about providers so they can reward high-quality, cost-efficient providers with more patients.

The belief is that the “buy right” concept will force providers to compete on quality and cost efficiency and stave off further government control, but its progress throughout the country has been sluggish so far.

Battles between providers and business preceded the adoption of mandated public release of illness severity-adjusted hospital outcome figures in Pennsylvania, Colorado and Iowa.

Cleveland’s effort has achieved consensus so far, maybe because

Reimbursement

the data released to business purchasers will not be made available to the public, or perhaps because cooperation between the three big players has been secured first.

However, Powell Wood, vice president of the Nestle Corporation, was quoted in an issue of *American Medical News* as saying: "But we won't really know how much buy-in we have until physicians and hospitals start losing patients, and hospitals begin to close. So far, the providers have shown no hesitancy."

If providers have shown no hesitancy, however, it's because a committee of the Academy of Medicine of Cleveland has studied this issue in-depth and are comfortable — at least for the moment — with the way the project has been structured.

Ronald L. Price, MD, Fifth District Councilor to the OSMA and the Cleveland Academy's immediate past president, is one of those who has been involved with the initiative from its start-up.

According to Dr. Price, the academy decided to participate in the project once it learned that industry, in another cost-cutting move, was selectively contracting with certain hospitals in the area.

"We were concerned about our patients' access to care, and to the quality of care they would receive," he says.

Yet every framework that has been tried previously in this area seemed to indicate that this new coalition with business and hospitals was not going to work.

"Nothing like this (three-way partnership) had ever been tried," says Dr. Price, "but we decided we had nothing to lose in joining the attempt."

He is quick to point out that



physicians receive no direct benefit from their participation in the project — although they may experience an indirect benefit as quality of care for their patients is ensured or improved.

The point Dr. Price most wants to make about the academy's participation, however, is that business is *not* deciding any medical issues.

"The members of the academy committee that studied this project have worked very, very hard to establish parameters," he says.

"The project is one that evaluates the quality of care of *hospitals*. It does not evaluate physicians, nor does it evaluate an individual physician's care in hospitals. A lot of people don't understand that."

The project is not now — nor will it be when it begins on January 1, 1992 — another type of physician peer review.

"There has been absolutely no discussion of this project expanding its scope in this direction," says Dr. Price. If it did, the academy would withdraw from its involvement.

As it is, there are no guarantees that industry is going to derive any useful information from this ambitious initiative. Certainly the fact that it has the three-way cooperation of physicians,

hospitals and industry gives it an advantage over similar concepts that have been tried in the past, yet the data collected may be of little or no use in selecting facilities that offer quality care.

"Industry knew this going in," says Dr. Price. "They knew the figures may reveal nothing of quality and that all of this may be for nothing."

Even still, the academy does not regret its initial involvement.

"How can you discuss quality of care and *not* involve physicians in the discussion?" he asks.

There's little reason to doubt that as business and industry, health-care's major purchasers, look for other ways to cut costs *and* ensure quality of care, similar discussions will take place more and more often in the future.

"Right now, Claire Wolfe, MD, OSMA Tenth District Councilor, is having similar meetings with business in Columbus, so yes, this type of project is something we're going to see more frequently across the state in the future," says Dr. Price.

The Cleveland initiative, which has assumed the name Health Quality Choice Program, might well prove to be the model for such projects — but it will be at least another year before anyone knows for sure. **OSMA**

We'd Better Start Listening

By A. Robert
Davies, MD



It is important that we listen carefully to one another, to the business people who tell us medical care coverage (whether insured or self-insured) is too costly; to the manufacturers who tell us their products lose out in

the international marketplace because of cost competition; to our medical associations, all of which have come up with suggested solutions for the future; and even to

the insurance companies and the review organizations that are trying to separate the wheat from the chaff and need help saving the wheat.

In addition to listening, there are several other rules we must observe if we are to communicate effectively with each other, with government, with business, with insurers.

- "They've got a bunch of people who don't know anything about medicine up there denying my insurance claims for medical services . . . can't even pronounce the words right."

Evidence () Anecdote ()
• "Flunked out of high school, got a job right away with Medicare."

Evidence () Anecdote ()
• "Can't be too tough. He moved to town, hung up a shingle and bought a Mercedes-Benz, all in the first week."

Evidence () Anecdote ()
• "I'll tell you how they do it! They get you on the line and then keep you there, asking asinine questions any fool should know the answer to while the office schedule goes to h—. That's preadmission certification!"

Best of group () Average () Worst of group ()
• "Here's what these surgeons do! They do an operation and then charge you for all the little pieces of it; I mean a hysterectomy and they charge for exploratory lap, lysis of adhesions, oophorectomy, removal of an old scar, and a mole on the way out!"

Best of group () Average () Worst of group ()
• "They never listen to you! Just usher you through and pay on the way out of the office."

All internists () Average () Worst internists ()
• "By gosh! If they make a decision not to approve admission and later it's found to have been necessary, they should lose their license! Don't talk to me about

Continued on page 34

Shortage . . . continued

points out. "Fortunately, not having lifelong doctors in an underserved or rural area doesn't mean the area will go without needed medical care, only that someone new will come along for another four years," she says.

The loan repayment program discussed in the Ohio Legislature last year would have included only family physicians and general internists. The OSMA legislative department had sought to expand this to include pediatricians and obstetricians/gynecologists which are also in short supply, and great demand, in underserved areas.

The close of the 118th General Assembly at the end of 1990 ended any hopes for the enactment of S.B. 253. However, the sponsor, Sen. Robert Ney, (R-Barnesville), hopes to include a loan repayment program as part of the two year budget package to be debated by the 119th General Assembly during the first six months of 1991. OSMA

Elections . . . continued

And, he continues, "We elected two good friends of medicine to Congress — John Boehner, a Republican from West Chester, and David Hobson, a Republican from Springfield. Both have been supportive of medicine during their tenures in the General Assembly."

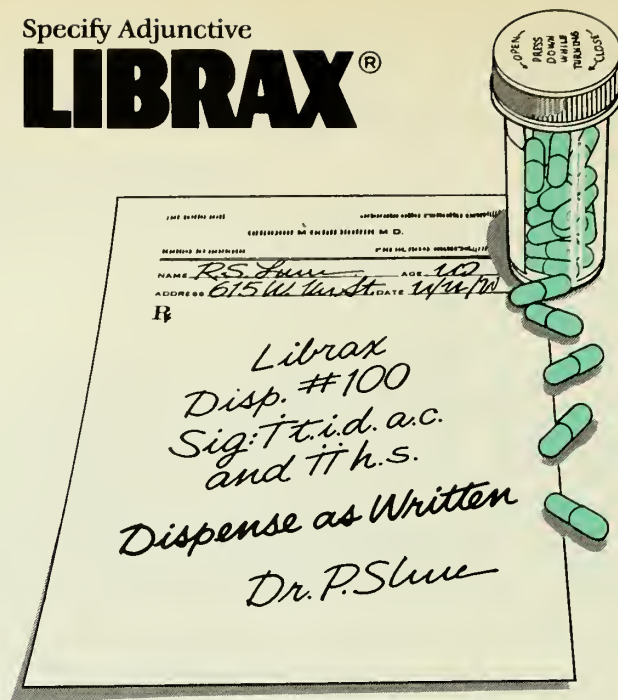
Van Doorn continues: "One example of Hobson's sterling health-care record is that he won the AMA's Nathan Davis Award for outstanding contributions to public health, the only state legislator so recognized in the country."

Regardless of who holds a particular elected office, however, Van Doorn concedes that it will be tough going for medicine in the public policy arena for the foreseeable future.

"It's going to be a very difficult legislative session; the very foundation of our health-care system is going to be challenged in ways that physicians won't approve," he says. "We're very fortunate that OMPAC possesses the resources and the political insight to invest in the re-election of those friendly to medicine." OSMA

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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlorthalidone HCl and/or clidinium Br.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur. Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlorthalidone HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlorthalidone HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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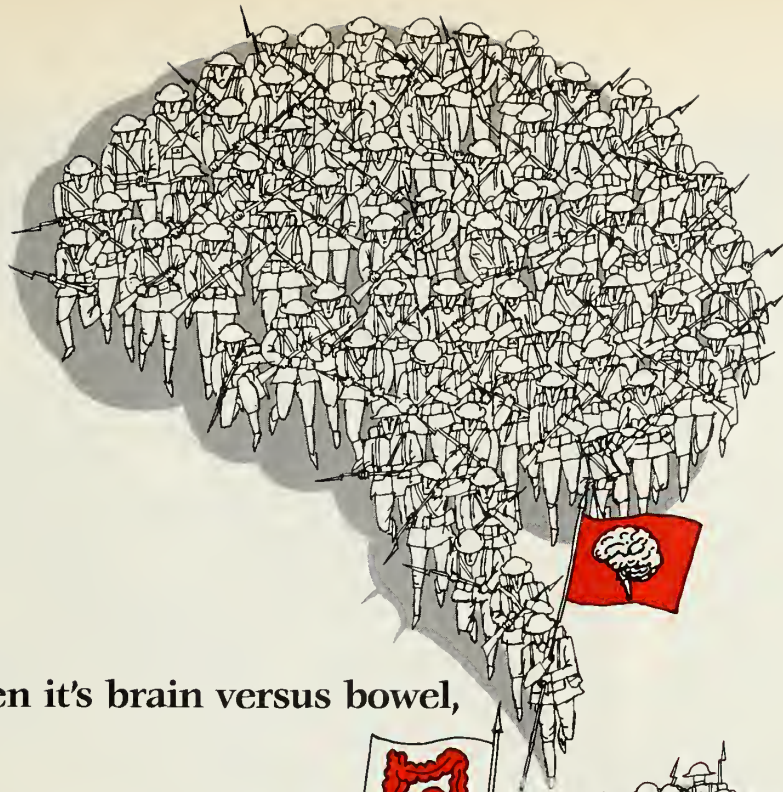


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Please see summary of prescribing information on adjacent page.



Rural Areas Losing Appeal for Young Doctors

• Since fewer and fewer medical students are choosing to practice in rural communities, these areas are scrambling to recruit physicians. So far, however, such lures as interest-free loans and other incentives are not enticing enough for young physicians. What are the rural areas to do? One Ohio county thinks a foreign medical graduate may be the answer, and it's working overtime to bring her onboard.

The appeal of rural America has dropped in the eyes of fresh, young medical graduates. No longer are students clamoring to open a practice in a nice, quiet, picket-fence sort of town. According to a study conducted by the Association of American Medical Colleges, about half as many students preferred rural practice today as those in 1981. Most of the 11,000 students queried, 88.7%, intended to practice in an area with a population greater than 10,000.

What this means is that slightly more than 26% of senior medical students preferred rural practice in 1981, while only 13.5% indicated the same preference in 1989.

Why the sudden drop? Ted Koler, clinic administrator of Barnesville Health Services, reasons that it's a combination of things. "Simply put, larger hospitals usually pay more. Plus, most doctors want to practice fairly close to where they complete their residencies," he said, adding,

"There's also limited or no cultural activities in small towns; and the increased trend of subspecialization has something to do with it. Also, rural physicians generally receive less reimbursement from Medicare than do their urban colleagues." Koler cites lack of job opportunities for spouses as another serious threat. "In many marriages, the female may be the physician. She may not want to work full time, but prefer to stay home with her family. This means that her husband must find a good-paying job to support the entire family," Koler points out. In many of Ohio's socioeconomically deprived areas, job selection is limited.

On the advice of his recruiter, Koler has sweetened the pot for his Monroe County Clinic. When the

Department of Labor insisted his \$60,000 base salary was too low, Koler hiked it to \$70,000, and now the salary can guarantee an internist approximately \$91,000 within three years. Koler also promises to pay moving and continuing medical education expenses, offers productivity reimbursement, and does his best to find job opportunities for the spouse. Other communities are doing much the same to lure recent graduates. Hicksville Community Memorial Hospital and Van Wert County Hospital offer interest-free loans to students who will commit to practice in their area following a residency program. Hicksville also offers free office facilities for two years and office staff for one year at their family health center.

The prospects of finding qualified physicians to work in rural areas has not always been so bleak. Up until five or six years ago there wasn't a problem, according to Koler. The National

By Karen Kirk



Health Service Corporation had provided scholarships to students with the understanding that they would work in a medically underserved area upon graduation. "Then we had dozens (of doctors) coming to our sites," Koler recalls. The program was eliminated when a study indicated a surplus of physicians. "What the study failed to show was that most of these students were going into specialties. Consequently, there is not a surplus of primary care physicians, especially not in rural areas," Koler says. After taking a closer look at the problem, the government-subsidized program has been reinstated with a new twist — now the program is not limited to just scholarship students.

In the meantime, rural communities have had to turn to other alternatives, one being the foreign medical graduate. However, this solution is not flawless. Koler and Monroe County residents have been petitioning Ohio politicians to persuade immigration officials to allow a Philippine physician to practice in Woodsfield — a community of about 4,000 — and help relieve the shortage of doctors in the county. Koler explains that the immigration service places stricter quotas on the number of physicians from the Philippines, Mexico and India allowed to work in the U.S. than it does on most other countries. "The process of getting a visa is long and drawn out, plus expensive," Koler says.

U.S. Sens. John Glenn and Howard Metzenbaum (both D-Ohio); U.S. Rep. Douglas Applegate, (D-Ohio); Ohio Sen. Robert Ney (R-Barnesville); and Ohio Rep. Jack Cera (D-Bellaire) have stepped in with letters of support. It's obvious that political differences have been set aside in an effort to work together and speed up delays with the immigration office.

Koler hopes that all of his efforts will bring Imelda Chia, MD, to the Monroe County Clinic

on a full-time basis after she completes her fellowship in internal medicine at the Cleveland Clinic in January.

Ideally, the Monroe County Clinic, which is the only medical facility in the whole county, should be staffed by three full-time physicians. Instead, the clinic is staffed by a full-time nurse practitioner and a physician and surgeon, who are available only part time. "There are 18,000 people in Monroe County," Koler points out, adding, "With three physicians we have roughly one practitioner for every 6,000 patients. If someone gets sick in Woodsfield and the clinic is closed, the closest medical facility is 20 miles away in Barnesville." Otherwise a person must seek medical attention 50 miles away in

Marietta or 30 miles in West Virginia.

A group of lawyers in Washington, D.C., is assisting Koler in his fight. "The attorneys are requesting a waiver of a residency requirement for the physician, trying to obtain a work certification through the U.S. Department of Labor and permission from immigration for Dr. Chia to remain in the country," he says.

Something must be done and fast. The administrator points out that these efforts have been under way for the past six months and that Dr. Chia has already signed a contract with the Monroe Clinic. The only hold up is the immigration office.

Monroe County faces the same physician shortage that other rural

counties nationwide must contend with. Unfortunately, Koler does not see the problem getting any better in the near future. Similar problems exist in inner cities as well, Koler says. According to the survey conducted by the Association of American Medical Colleges, when asked if the physician planned to locate in a socioeconomically deprived area, 81.8% said no, while 14.9% said yes.

Those staggering figures do not bode well with administrators in underserved, rural communities or in the inner cities. Obviously something must be done and done soon. **OSMA**

Karen Kirk is Associate Editor of
OHIO Medicine.

Fate of Bill Up in Air

The Loan Repayment Bill, S.B. 253 from the last General Assembly, would not solve all the problems relating to the crippling shortage of primary care physicians in underserved areas of the state, but the program is worthwhile and is a step in the right direction.

The bill, which passed the Senate last year, failed to make it through the House of Representatives because of the time constraints of the post-election lame duck session. "The loan repayment bill would have created a program to repay loans and expenses incurred by physicians in pursuing their post-graduate medical education," explains Cynthia Snyder, OSMA's associate director in the Department of Legislation. The catch? Those physicians would, in turn, contract with the state to provide primary health-care services in areas designated as underserved by the Ohio Department of Health.

Under the terms of the program, physicians specializing in family practice or general internal medicine would be eligible to apply for a whopping repayment of up to \$80,000 (\$20,000 per year for a maximum of four years of medical school) in loans or expenses incurred to finance their medical education. If accepted, the physician would be required to practice in an underserved area for a minimum of two years and a maximum of four years, depending upon the amount of the repayment.

Physicians who fail to serve their full term of agreement with the state would be subject to substantial penalties, Snyder says.

According to Susan Ewing-Ramsay, chief of primary care and planning for the Ohio Department of Health, the bill is similar to the tuition assistance provided by the National Health Service Corps in that it obtains physicians for underserved areas, but that's

where the similarities end. She points out that a loan repayment program makes more sense because the physician has already completed his or her medical education. However, Ewing-Ramsay is quick to point out that upward of 200 physicians were placed in Ohio thanks to the National Health Service Corps program. "Ohio is one of the largest trainers for physicians (with seven medical schools), but it's also the largest exporter. We have to find a way to keep physicians from moving to other states and into underserved areas," Ewing-Ramsay says.

A loan repayment program would keep more physicians in Ohio — if only for a few years. That's one of the criticisms of the concept. "There's this age-old vision of a country doc staying around forever. That's simply an unrealistic expectation," Ewing-Ramsay

Continued on page 22

Should OSMA Change Its Direction in the '90s?



- Last year, the Ohio State Medical Association commissioned a study of member and non-member physicians in an attempt to determine what directions the association should take in the 1990s. Last month, *OHIO Medicine* published the findings of the membership survey. This month, we continue with the survey findings of non-members.

Non-Member — Findings and Implications

It is important to discover attitudes and opinions of non-members as well as members so that associations can remain a viable force for physicians. This section outlines non-members' feelings toward membership in medical organizations in general and the Ohio State Medical Association specifically. A total of 135 non-members completed the survey. Responses are based upon this number.

Non-members were first queried as to their decisionmaking process for joining medical organizations. The following shows how the total sample rated the importance of each factor in considering membership in a medical organization. The higher the mean score, the greater the importance of each factor.

Q. How important to you are each of the following reasons in considering membership in a medical organization?

Please use a scale from 1 to 7 where 1 equals not at all important and 7 equals very important.

The total sample rated representation in state legislative/regulatory bodies (5.35) as most important, having a physician's interests communicated to the public (5.11) as second most important, and continuing medical education (5.09) as the third most important reason for joining a medical organization. When examining the number of years in practice by reason to join, physicians with 16 years or more in practice rated continuing medical education as their most important reason for joining a medical organization as opposed to representation in state legislative/regulatory bodies, which they rated as second most important. Also, physicians with 11-15 years in practice felt that peer discipline (5.04) and legislative/regulatory representation

were an equally important reason to join.

Differences also appear in second and third most important reasons by the number of years in practice. For example, physicians who have been practicing for 1 to 5 years rated continuing medical education (5.33) as the second most important factor as opposed to third by the total sample. Practitioners with 6-15 year's experience rated liaison with third-party payors (5.11) as the third most important reason, which was rated as seventh by the total sample.

Ohio State Medical Association

Respondents were probed as to their awareness of, and familiarity with, the OSMA. In addition, their past encounters and reasons for not joining or remaining a member were also examined.

Q. Are you aware of the following OSMA membership services? Please check all of which you are aware.

CME meetings, professional liability insurance, life and health insurance and *OHIO Medicine* were the OSMA's service offerings with the greatest awareness among non-members. To better understand non-members' awareness, these top four services were then cross-tabulated by number of years in practice.

This breakdown indicated that physicians who have been in practice five years or less have the greatest awareness of OSMA's membership services, and that overall, awareness of OSMA membership services declines the longer a non-member has been in practice.

The *OSMAgram* (47.1%) generated the most awareness for physicians who have been in practice five years or less. The *Medical Staff Bulletin* (29%), professional liability (28%), and health and life insurance (28%) achieved top awareness for physicians in practice for 6-10

years. For physicians who have been in practice 11-15 years, legislative representation was the OSMA membership service that was highest in awareness. Physicians in practice for 16 years or more showed little awareness of OSMA membership services, as no one service received a response of over 20%.

Q. Overall, how familiar do you feel with the OSMA?

The majority of non-members are somewhat or not at all familiar with the OSMA. The greatest familiarity with the OSMA is represented by physicians who have been in practice 6-15 years.

Q. Have you ever been a member of the OSMA?

Of the respondents who were once a member of the OSMA, 47.5% had been practicing for 5 years or less; 30% for 6-10 years; 10% for 11-15 years; and 12.5% for 16 years or more.

Q. If yes, for how many years?

Of the 42 respondents who were once a member of the OSMA, nearly half had been a member for three years or less. In addition, approximately one-fourth of the respondents indicated their membership lasted four or five years.

Q. If yes, why did you drop membership?

The most common reasons for dropping membership in the OSMA cited by respondents were: the expense of membership and advantages and benefits were not clearly communicated. Other reasons concerned membership in county and national societies and the organization's effectiveness.

Q. If you've never been a member, have you ever been approached to join the OSMA?

Of the 45 respondents who had been approached to join the OSMA, 34% had been in practice for 1-5 years; 9% for 6-10 years; 37% for 11-15 years; and 20% for 16 years or more. On the other hand, of those 38 respondents who

indicated they had not been approached to join the OSMA, 40% had been in practice for 1-5 years, 24% for 6-10 years, 16% for 11-15 years, 21% for 16 years or more.

Q. If yes, please indicate the manner in which you were contacted.

Of the 91 respondents who have never been a member, 49.5% (45) had been approached to join the OSMA. The majority (34/75.6%) of these contacts were made through the mail.

Q. Why didn't you join?

The number one reason, as cited by non-members, for not joining the OSMA when contacted was cost. Also, non-members mentioned the cost/benefit ratio and memberships in other organizations as reasons for not joining the OSMA.

The statements that yielded the most agreement from respondents were:

- I believe membership in my specialty society is more beneficial (61.5%)
- The dues are too high for what I get in return (51.1%)
- I am experiencing financial difficulties, I can't afford the dues (37.8%)
- I do not know what benefits OSMA offers (37%)
- I don't know enough about the OSMA to decide whether I want to join (34.8%)

Overall, the neutral category received a high number of responses, however, respondents were particularly neutral on two statements:

- OSMA's philosophy is not considered with my own (58.5%)
- My opportunities for leadership would be too limited (57.8%)

Disagreement was highest for the statements:



Long-range plans for the OSMA

The results of the OSMA Member/Non-Member Survey, conducted in February by the Columbus-based marketing firm Market Group One, is now in the hands of OSMA's Long-Range Planning Committee.

This committee is currently reviewing the strategies and recommendations the report contains, and is making decisions on whether or not the recommendations should be implemented and, if so, how these changes might be best accomplished.

Members of this long-range planning group include all members of OSMA's Committee on Auditing and Appropriations: Jack L. Summers, MD, Akron; Walter A. Reiling, MD, Dayton; Claire V. Wolfe, MD, Dublin; the Eighth District Councilor: Thomas J. Hall, MD, Newark; and the president of OSMA's Medical Student Section, Larry Frick, Cincinnati. **OSMA**

- I have never been asked to join (47.4%)
- The members of OSMA are much older than I am (39.2%)

From this analysis, it is clear that non-members are not perceiving the benefits of the OSMA, particularly when compared to the cost of the dues and other specialty societies.

Demographics

In order to form a demographic profile of non-members, several questions relating to respondents' practice were asked.

Overall, non-members are in either solo (23.7%) or group practice (27.4%). Over half (56%) of the responding physicians practice in the city, another 26% practice in the suburbs and 14.1% consider their practice area rural. Geographically, non-members from the northeast accounted for 29% of the sample, while 30% were from central Ohio and 14% were from the southwest. The northwest and southeast comprised 6% and 2% of the total sample respectively. The largest group of non-member physicians surveyed (41%) has been in practice for 1-5 years, followed by 22% of the physicians, who have been in practice for 6-10 years. Three quarters of the sample are male. The most common medical specialties indicated by respondents were general/family practice (24%), pediatrics (16%), internal medicine (14%) and emergency medicine (7%). **OSMA**

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Establishing Patient Rapport

- An effective doctor-patient relationship serves as a major element in reducing malpractice suits. Here are additional reminders that may be helpful.

Taking the time to talk with your patients — becoming aware of their expectations and fears — can lessen the anxiety that occurs naturally when patients

are upset and dealing with the pain of illness.

Here are some additional reminders that may be helpful in establishing or assessing the rapport between doctor and patient.

Remove as many potential blocks to rapport as possible.

Don't give your patients the basis for complaints.

Accept only those patients you are willing to treat.

There may be patients with whom you cannot establish good rapport or a satisfactory therapeutic relationship. It will be better if you do not undertake treatment of them.

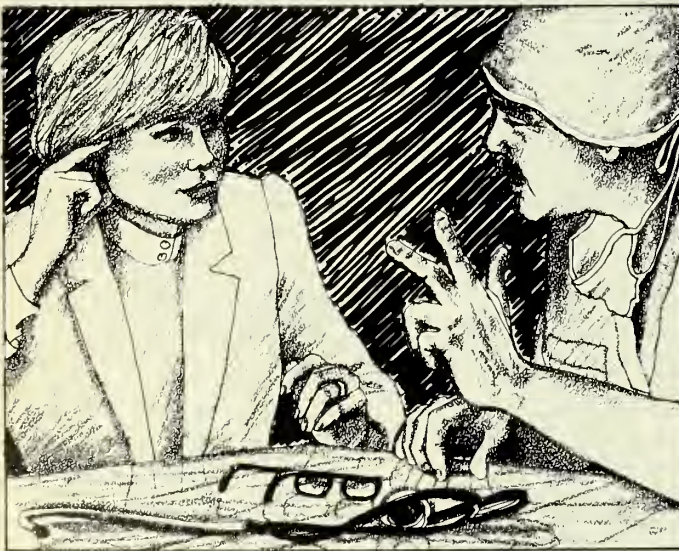
However, in these instances, be careful not to abandon the patient. Referrals to other physicians are necessary. If the patient has an urgent medical problem, you should make it explicit that you will treat that problem *only*, then will assist the patient in finding another physician.

Recognize that some patients are "lawsuit prone" and learn to take special care with them.

Here are some warning signals:

- Patients with overly strong criticism of previous doctors;
- Patients who are doctor-shoppers;
- Suspicious, neurotic or severely hypochondriacal patients;
- Patients with unrealistic expectations;
- Overly demanding or "consumeristic" patients;
- Patients who stubbornly resist complying with instructions;
- Patients overly concerned with money;
- High-risk medical problem patients;
- Overly grateful patients and obvious flatterers; and
- Patients who are compulsive note-takers.

Give some thought to your practice size, and the number of



Loss Awareness

patients you can treat with thorough and appropriate care.

Overextended schedules not only increase the likelihood of errors, but they also can tax your attentiveness to patients. This is a major source of patient dissatisfaction.

Do not assume responsibility for care and treatment that you are not fully qualified to undertake.

After assuming responsibility for a patient, the doctor must render skill and care — in diagnosis and treatment — equal to the standard of colleagues in the same specialty. If lacking all the professional skills needed to treat the patient, it is wise to refer the patient to a specialist.

It's also important that specialty procedures you perform are well within the standards of care. Such specialty procedures require specialty education, specialty training and specialty experience — measured against national specialty standards.

Be prepared to discuss with patients any unusual fees prior to treatment.

If a fee will be higher than usual, it needs to be discussed with the patient before the service is rendered. You should arrive at an understanding with the patient on the matter of fees; therefore, it also may be advisable to discuss all fees in advance, regardless of size.

Impractical or insensitive collection methods and mishandled billing procedures, especially when coupled with unexpected fees, are common triggers for malpractice claims.

Exercise tact in your relationship with patients — but always be alert for liability problems.

Attentive doctors are able to sense disturbing undercurrents in

the doctor-patient relationship at a reasonably early point. In so doing, it is important to quickly institute some protective measures; this can prevent such undercurrents from developing into something much more unpleasant or threatening.

If a patient is not showing satisfactory progress, a consultation may be needed. If a patient begins to complain and appears to be dissatisfied — or if members of the patient's family

show dissatisfaction — consultation becomes vital. In such instances, the consultation (and one that is properly documented) affords considerable protection for the doctor against a potential malpractice claim. **OSMA**

The Loss Awareness Bulletin is provided each month through the OSMA Task Force on Professional Liability and its subcommittee on Loss Awareness.

PEP . . . continued

Another point Dr. Carden wants to emphasize is that, in each situation, any impaired physician will be working, not only with the full-time staff, but also with a physician volunteer who is a member of the program.

Initially, PEP hopes to include osteopaths and podiatrists as well as MDs in the network. Representatives of both the Ohio Osteopathic Association and Ohio Podiatric Medical Association have participated in recent planning sessions.

In the future, the committee expects to establish an even broader network with other professional groups, such as nurses, veterinarians, pharmacists and perhaps even the bar association.

"Such a link-up would send a message, loud and clear, that we can take care of our own," says Clinger, "and we can work with others to help accomplish that goal."

In the meantime, the PEP committee is anxious to see the new staff in place and functioning. Everyone will



benefit, says Dr. Carden.

"Just remember," he says, "that the public welfare, and the welfare of the individual impaired physician, are inseparable." A program that leads to certain diagnosis and treatment of these physicians before they are a threat to the public is the optimal method of managing this problem. **OSMA**

Commentary . . . continued

intent or malice or due process or honest mistake. If it's wrong, it's wrong!"

Judge all () Only use for U.R. organizations ()

• "By gosh! If they make a decision to admit and later it's found not to have been necessary, they should lose their license! Don't talk to me about . . . honest mistake. If it's wrong, it's wrong!"

Judge all () Only use for admitting physicians ()

• "Why don't you guys just spot check so many of these from each doctor and then concentrate on the people who are doing it wrong instead of wasting time looking over the shoulder of the people who are doing it right virtually all the time?"

Good idea () Good idea only if we thought of it ()

• "Laparoscopic surgery should save health-care dollars in the aggregate. Recompense should be used on what is being done, however, not on what is no longer being done. That is: One should be paid based on time, complexity, resource costs, opportunity costs, liability risk, requisite skill and the like, not on how much is saved by a shorter hospital stay."

Good idea () Good idea only if we thought of it ()

All of us as doctors, insurers, government, business people and health-care coalitions should adopt a standard set of guidelines for talking to each other. Hyperbole should be stifled. Honest expression should prevail. Robert's Ever-Expanding Rule for Fair Communications:

1. Discern the difference between evidence and anecdote. One

should act on evidence and not react to anecdote.

2. Exercise care in our judgments lest we characterize a whole group by the actions of the worst of the group.
3. As we judge others, we must understand we may be judged by the same measure.
4. We should pick up on new ways of doing things, even if we didn't think of it first.
5. Listen carefully. Listen carefully. Listen carefully.
6. More rules to follow. **OSMA**

A. Robert Davies, MD, is vice president, chief medical director, Nationwide Insurance, Columbus. This article originally appeared in "Internal Affairs," the newsletter of the Ohio Society of Internal Medicine.



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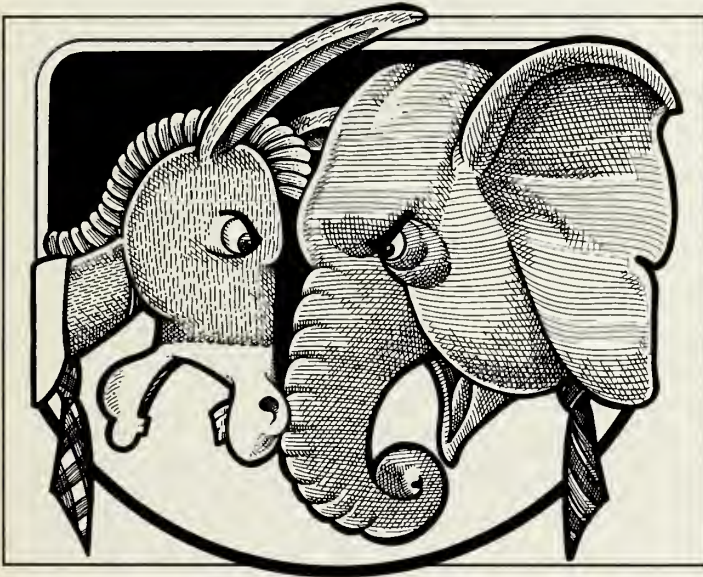
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Major Issues Facing Medicine in 1991

If you were to ask three different physicians to name the top issue facing medicine,



you'd no doubt get three different answers. But according to John Van Doorn, OSMA's director of the Department of Legislation, there is clearly only one issue of utmost concern to medicine.

"No question about it," says Van Doorn, "at the top of the list is the universal health-care bill."

The topic of much debate over the last year, Van Doorn says the arguments for and against universal health care will continue to rage in 1991.

Right now, "The Legislature is redrafting H.B. 425, the bill that would establish Canadian-style universal health care in Ohio," Van Doorn says. "With the redraft, they're trying to calculate its cost. For example, the original bill would've cost around \$28 billion to implement. Money from all sources identified in the bill would've raised \$19 billion, which would've left about a \$9 billion gap."

Van Doorn predicts that the new bill will still call for raising taxes,

but legislators will scale back the plan in order to make up the approximate \$9 billion gap.

Meanwhile, the Task Force on Health Care and Health Insurance, which is chaired by Rep. Mike Stinziano of Columbus, is trying to come up with alternatives to universal health care.

"My guess is that they're looking at a package of proposals to control health-care costs," Van Doorn says. "It's likely that it's going to contain a strong dose of health-care cost containment as well as several proposals to expand access to care, including a requirement that business provide its employees with medical coverage."

Another consideration is Gov. Voinovich's health-care proposals, which call for creating a state risk pool for Ohioans with pre-existing medical conditions, and passing legislation to allow small businesses to more easily form group health insurance pools and to provide no-frills insurance plans.

"Access to health care is really the top issue," Van Doorn sums up. "That overshadows everything else that happens next year."

To be fair, however, medicine *will* be facing other health-care issues.

A second important issue physicians will face "would have to be malpractice immunity for physicians providing care to indigent Ohioans," Van Doorn says. "This is when you provide medical care in any setting to indigent patients."

Although Van Doorn concedes

Legislation

that he is unsure how the issue will be resolved, "The OSMA will be exploring with legislators several different options, one of which is S.B. 251, which gives physicians a qualified immunity from liability for providing free diagnosis care and treatment to indigent patients."

Medicine's third priority for the coming year will be living wills, according to Van Doorn.

"The OSMA and the Ohio State Bar Association have joined forces to introduce legislation to establish living wills in Ohio statute," Van Doorn says, noting that "Ohio is one of only seven states that

"The OSMA and the Ohio State Bar Association have joined forces to establish living wills in Ohio statute."

doesn't legally recognize living wills."

Although proposed living will legislation has been around for years in Ohio, "The Right to Life group and the Catholic Conference of Ohio have vigorously opposed most living will legislation and have stopped it from going through the General Assembly," Van Doorn says. However, he adds, "The time may be right for living will legislation."

Of course, universal health care, malpractice immunity and living will legislation won't be the only issues of concern. "The OSMA will continue to battle *all* the issues it has fought over the past years," says Van Doorn, such as opposing optometrists' rights to prescribe therapeutic drugs and medical board legislation that severely sanctions physicians and mandatory Medicare assignment. **OSMA**

What the 1990 Elections Mean to Medicine

The 1990 elections are over, but whether or not your favored candidates won, the results will have an impact on the future of medicine. John Van Doorn, OSMA's director of the Department of Legislation and treasurer of the Ohio Medical Political Action Committee (OMPAC), spoke with *OHIO Medicine* about some of Ohio's elected officials and their view of health care.

For starters, says Van Doorn, the re-election of Justice Craig Wright to a six-year term on the Ohio Supreme Court was a major boost for physicians. Wright, a Republican, won with 1.3 million votes, just narrowly edging Stephanie Tubbs Jones, a Democratic judge in Cuyahoga County Common Pleas Court, who garnered 1.24 million votes. (A third candidate, J. Ross Haffey, a Cleveland lawyer, took 282,000 votes.)

"Justice Wright's re-election was crucial to the interest of medicine," says Van Doorn, "especially where medical malpractice cases that come before the court are concerned."

For instance, Van Doorn goes on to say, "he was particularly vocal on our behalf when he dissented against the damaging 1987 *Hardy vs. Vermuelen*, which declared unconstitutional Ohio's four-year statute of repose for medical liability claims."

While the results of that trial essentially leave physicians open indefinitely to malpractice claims, "Justice Wright wrote a blistering dissent," says Van Doorn.

Another elected official medicine will be watching closely is, of course, Gov. George Voinovich, who prior to the election outlined a number of health-care reforms

he would like to see implemented.

Says Van Doorn, "While OMPAC didn't endorse either candidate, we expect to have a strong working relationship with the Voinovich administration and have already begun to communicate with them on the issues of importance to physicians — initiatives to expand access to health care and to control health-care costs, as well as discussion of appointments to government agencies that affect medicine."

Prior to the election, "The OSMA conferred with Voinovich policy advisers and expressed our support for his initiatives to allow small businesses to provide "no-frills" health insurance, to create a state risk pool for those with pre-existing medical conditions and to enact living will legislation."

Not all of the governor's proposals sit well with physicians, however, especially his proposed mandatory Medicare assignment, which, Van Doorn says, "the OSMA will vigorously oppose."

Van Doorn also points out that the Senate Republicans, led by President Stanley J. Aronoff of Cincinnati, and the House Democrats, led by Speaker Vern Riffe of Wheelersburg, each added two members to their majorities. Republicans will control the Ohio Senate by a margin of 21-12 for the next two years, while Democrats will be in charge of the Ohio House by a 61-38 margin.

What does that mean for medicine? "OMPAC supported both the Senate Republican and House Democratic caucuses," Van Doorn says, "whose leaders have been responsive to the concerns of medicine over a long period of time."

Continued on page 22

Toward a New PRO Frontier

• Peer Review is shifting its emphasis from case-by-case assessments to the larger-picture goal of education.

The buzzwords for the future of health-care review suggest a deliberate move toward a less punitive role for peer review

organizations (PROs).

There is a shift in emphasis from case-by-case assessments to larger-picture examinations of the provision of health-care services.

Indeed, the Institute of Medicine and the Health Care

Financing Administration have both adopted the abstract concept of "NuPRO" to designate the move *away* from punitively

oriented, individual case reviews. We appear to be at the threshold of a major reformation in utilization and quality review, a trend Peer Review Systems, Inc. (PRS) finds consistent with its goals toward emphasizing education and improving quality health-care delivery. PRS is among the first PROs nationwide to dedicate a department to research and development. All of our data is analyzed with *education* in mind, and we constantly seek new, alternative ways to review which will enhance that goal.

As part of its commitment to innovation and education, PRS participated last year as one of 12 PROs in a federal pilot study to test methods of small-area analysis. Such analysis promotes feedback to physicians, regarding practice patterns for specific disease information, and self-assessment as to causes and appropriate interventions. Small-area analysis promises to occupy an increasing role in PRO review in the future and in other markets as well. In anticipation of this, PRS is developing its small-area analysis so that it will provide



By Kathleen K. Renz

Peer Review

extensive, sophisticated analysis of such variables as mortality, costs and length of hospital stay for specific illnesses, procedures, treatments and other factors. In addition, PRS has recently published articles based on analysis of its Medicare data base, the most comprehensive collection of such data for Ohio. Such publications are offered as an educational resource to physicians nationwide on a variety of medical and surgical issues.

The PRS Continuing Education Committee (CEC) is another active and vital component of the PRO's commitment toward a review system based on education, feedback and non-punitive intervention. A subcommittee of the PRS Board of Trustees, the CEC is composed of physician,

hospital and beneficiary representatives from across the state. The CEC's charge is to advance and coordinate educational programs that relate to PRS activities, for public, provider and physician communities, and to initiate new programs based on identified needs.

Of critical importance to the CEC's objectives, and to PRS overall, is the continuing development of a strong physician membership. PRS, as an organization formed by and for physicians, offers to all practicing Ohio physicians the opportunity for an active voice in its governance. Physicians have only to submit to PRS a written request for membership. (Forms are available from the PRS offices.) As members, they may then vote on corporate bylaws and board

member nominees. Every physician is encouraged to take a moment to complete a form and vote — ensuring *true* peer review in the PRO program.

As the gears of health services review continue to turn toward an analytical and educationally based system of health-care evaluation, PRS will continue to occupy the forefront in such efforts. Interaction with Ohio's physicians and early resolution of questioned care based on efficient and accurate communication will play an increasing role in PRS's review responsibilities and goals. **OSMA**

Kathleen K. Renz is director of Research and Development Operations at Peer Review Systems, Inc.

Obituaries

DON D. BRANNAN, MD, Ft. Myers, FL; Case Western Reserve University School of Medicine, 1936; age 81; died October 7, 1990; member OSMA and AMA.

ROBERT L. CUSTER, MD, Bethesda, MD; Case Western Reserve University School of Medicine, 1953; age 63; died September 4, 1990; member OSMA and AMA.

LAWRENCE HADBAVNY, MD, Cleveland; New York Medical College, New York, NY 1947; age 67; died November 3, 1990; member OSMA and AMA.

JAMES F. MORTON, MD, Zanesville; University of Cincinnati College of Medicine, 1940; age 75; died September 19, 1990; member OSMA and AMA.

JOHN H. PAIGE, MD, Amherst; Hahnemann Medical College of Philadelphia, Philadelphia, PA 1956; age 60; died September 26, 1990; member OSMA.

LEWIS K. REED, MD, Youngstown; Case Western Reserve University School of Medicine, 1933; age 81; died October 24, 1990; member OSMA and AMA.

JAMES A. STANFORTH, MD, Massillon; Case Western Reserve University School of Medicine, 1954; age 62; died October 8, 1990; member OSMA.

ROBERT P. ULRICH, MD, Colorado Springs, CO; Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1942; age 74; died September 5, 1990; member OSMA and AMA.

MARINO F. VIDOLI, MD, Cape Coral, FL; Facolta Di Medicina e Chirurgia dell 'Chirurgia dell' University di Roma, Roma Italy, 1924; age 91; died September 22, 1990; member OSMA and AMA.

ALOIS H. WILLKE, MD, Cincinnati; University of Cincinnati College of Medicine, 1935; age 82; died October 17, 1990; member OSMA and AMA.

Research

New drugs being tested for better AIDS treatment

Case Western Reserve University's School of Medicine is experimenting with some drugs that show promise against the AIDS virus. The clinical trials are being conducted at 46 other sites across the country as well as on people infected with the AIDS virus.

The test will compare the drugs to AZT, which has proved effective against AIDS in clinical trials since August 1989.

AZT doesn't cure acquired immune deficiency syndrome; it simply slows the progression. The newer drugs will not be a cure-all either, but researchers hope the drugs might do a better job of slowing the progression. If nothing else, the drugs will give physicians another weapon against the disease.

Although AZT may slow the process, the drug does have side effects not everyone can tolerate. For starters, it inhibits production of red blood cells, which leads to anemia, and white blood cells, which leaves the body susceptible to infection.

A drug similar to AZT called ddI (didanosine), made by Bristol-Myers Squibb Company, also prevents the virus from multiplying. This drug is not without side effects, but the side effects are different. This drug can create painful nerve problems in the arms and legs and cause inflammation of the pancreas.

However, in two studies conducted in New York and Massachusetts of 71 patients it was indicated that ddI increased the number of T4 helper cells. These white blood cells play a crucial role in the body's defenses against infection.

So far, the studies have indicated a decrease in the amount of AIDS virus in the patient's blood, plus an increased weight gain, both positive signs.

These clinical trials will demonstrate how well ddI works compared to AZT. The study is divided into three groups:

- Patients who have been taking AZT for 48 weeks or longer. A third of these patients continue taking AZT only; the other two-thirds take ddI instead of AZT. This is the group for which the benefits of AZT begin to fade.
- Patients who have used AZT for a short time or not at all. One-third of this group are given AZT, and two-thirds are given ddI. The results from this group will show whether ddI works better than AZT at the beginning of treatment.

- Patients who can't tolerate AZT, who are taking ddI. This part of the study will show whether people who can't take AZT can be helped by ddI. The group will be subdivided into three smaller groups, each of which will be given a different dosage level. This will help researchers determine which dose works best.

"The ddI trials will continue until enough data is gathered to conclude how well the drug works," says Michael M. Lederman, an associate professor of medicine and the principal investigator of the Cleveland AIDS clinical trials.

So far, 1,409 patients have been enrolled nationwide; in Cleveland 25 people have been enrolled in the ddI trials.

The medical school is also participating in studies in which other experimental AIDS drugs are being used. Among the drugs being tested or soon to be tested are:

- Human recombinant erythropoietin or EPO. This drug stimulates the production of red blood cells. Previous studies have shown that it helps very ill AIDS patients. The study will show if it will help those infected with the AIDS virus but showing no or only mild symptoms of the disease, according to Lederman.

- Rifabutin. A trial will begin shortly to test the drug's effectiveness against mycobacterium avium infection in AIDS patients.

- Nimodipine, a calcium channel blocker. A study will investigate nimodipine in the treatment of AIDS dementia.

- ddC (dideoxycytidine) a drug similar to AZT and ddI. A study will show if lower doses of AZT and ddC will be effective against AIDS while resulting in fewer side effects.

Researchers at CWRU's School of Medicine hope that through the testing of experimental drugs a better treatment for the AIDS virus will be uncovered. **OSMA**



Heart attack risk-reduction studied

"If you get a health-care professional telling you that you will have a heart attack, chances

Research

are you will change your ways," says a 43-year-old Willoughby Hills resident who suffered a heart attack last year.

This resident and 20,000 other northeast Ohioans will benefit from a new study conducted by Meridia Health System's Heart Institute that will examine risk factors related to heart attacks.

Philip P. Brous, MD, director of cardiology at Meridia Euclid Hospital, was chosen to direct the northeast Ohio leg of the study. "I saw it as a very positive step," he said, adding, "It sounded very exciting."

Meridia Euclid, Hillcrest, Huron and Suburban hospitals will be working with Health Cleveland hospitals, Fairview General and Lutheran Medical Center to perform the study locally, on both the east and west sides of Cleveland.

Five risk factors and their relationship to heart disease will be studied. More than 20,000 northeast Ohioans will be offered free initial risk-factor tests and follow-up exams at minimal cost to examine: cholesterol, blood pressure, diabetes, weight and smoking.

The 500,000 people involved in the nationwide study will be tested at 25 hospitals twice a year during the five-year period to examine the modifiable risk factors. Dr. Brous hopes the study will make people more aware of the risks.

The five risk factors will be measured, and these numbers will serve as a guide for the study. **OSMA**

Treating addicted veterans

Wright State University School of Medicine and the Dayton Veterans Administration Medical Center will begin a \$5.9 million clinical research project that will

seek new ways of treating service veterans addicted to crack. The National Institutes of Health is funding the grant.

At least 600 Vietnam War veterans will take part in the project over its five-year period. The study will investigate which methods are most successful in treating cocaine addicts and how to stem the high treatment drop-out rate among addicts.

According to Harvey Siegal, a Wright State professor and director of university substance abuse programs, Vietnam veterans have been hard-hit by the crack epidemic and crack addicts are,



traditionally, more resistant to treatment than alcoholics and abusers of other drugs.

Vets who volunteer to participate in the program will receive a variety of treatments, including WSU's weekend intervention program (see the January issue of *OHIO Medicine* for a write-up of this program); the VA's 30-day inpatient substance abuse program; and Narcotics Anonymous. New, cocaine-specific treatment programs may also be developed during the course of the study.

Participants will be followed by researchers for 18 months after initial treatment. They'll be asked to take voluntary urine and AIDS tests. The latter will give researchers more information on the relationship between the HIV virus and cocaine abuse. Researchers say it will be a year before any preliminary data is reported. **OSMA**

Study to determine how body handles infection

Ann Bjornson, director of the Division of Immunology at the James M. Gamble Institute of Medical Research, has been awarded a grant from the National Institutes of Health for the study of opsonins.

Bjornson will attempt to identify the biochemical signals involved in the activation of white blood cells by pure forms of opsonins. She also will determine the structural features of the opsonins that mediate activation of the cells. The fundamental knowledge derived from this study will increase understanding of how the body combats severe infections. **OSMA**
Do you have a research project you would like to report? Please send information about the project to: Executive Editor, OHIO Medicine, 1500 Lake Shore Drive, Columbus, OH 43204-3824.



Ann Bjornson, James M. Gamble Institute

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Oncology February 2

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March 1-2

Major Advances in Oncology:
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University Hospitals of Cleveland/CWRU
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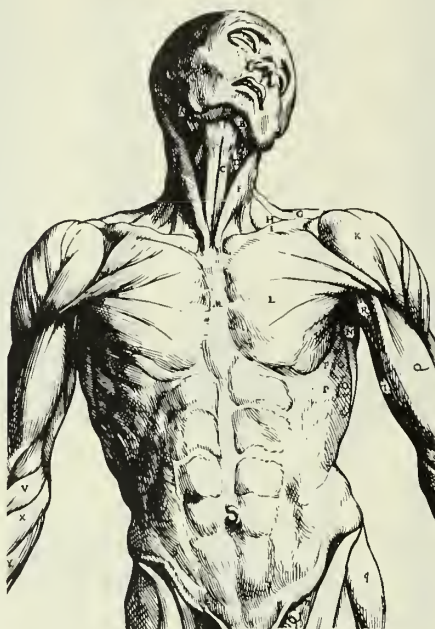
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Dermatology February 8-9

Dermatology for the Non-Dermatologist
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Obstetrics March 7-8

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For more information, call (800) 492-4445.

Cincinnati

Otolaryngology March 22-29

Contemporary Concepts in Otolaryngology
Caneel Bay Resort, St. John, U.S. Virgin Islands
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COLUMBUS, OHIO: Physician needed to staff urgent care facilities. Competitive salary, full benefits. Respond with CV to Paul Zeeb, MD, Medical Director, Primary Medical Associates, Inc., 4900 Gettysburg Road, Columbus, OH 43220.

DIRECTOR OF CARDIAC REHABILITATION SERVICES — The Department of Internal Medicine, Division of Cardiology at The Ohio State University is seeking a Board-certified cardiologist at the associate professor level to direct a major expansion of the existing cardiac rehabilitation program. A challenging opportunity exists with 28 other faculty

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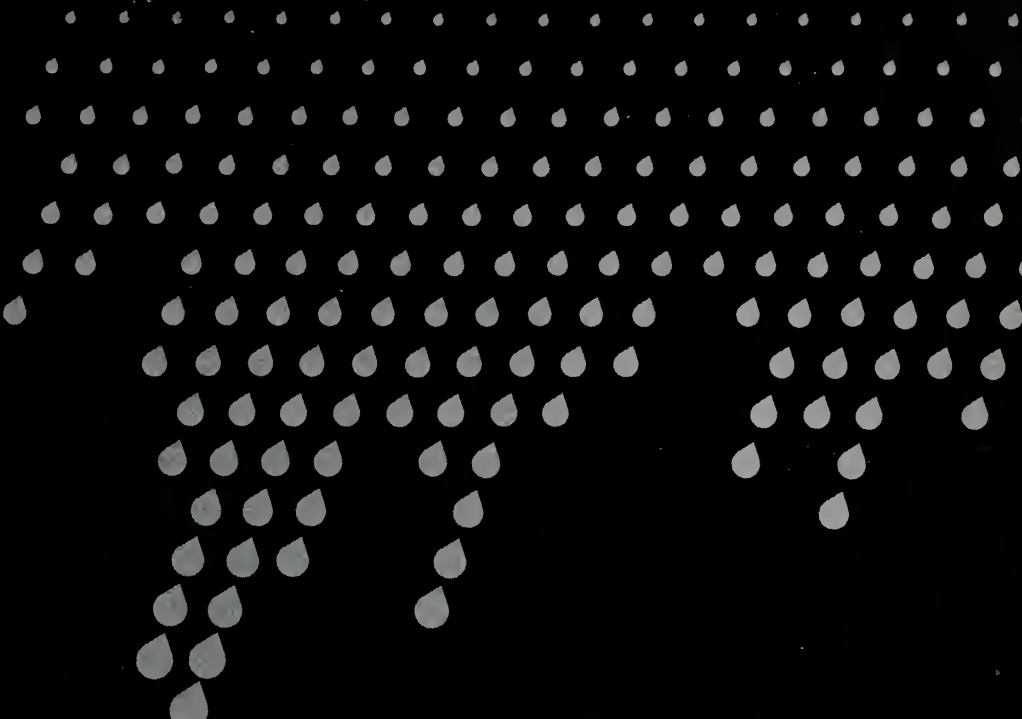
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***with once-a-night
therapy for active
duodenal ulcers***

Zantac[®]300 
ranitidine HCl/Glaxo 300 mg tablets

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Glaxo Pharmaceuticals

See adjacent page for Brief Summary
of Product Information

In active duodenal ulcers

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Zantac[®] 300
ranitidine HCl/Glaxo 300 mg tablets

Zantac[®] 150 Tablets
(ranitidine hydrochloride)

Zantac[®] 300 Tablets
(ranitidine hydrochloride)

Zantac[®] Syrup
(ranitidine hydrochloride)

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac[®] product labeling.

INDICATIONS AND USAGE: Zantac[®] is indicated in:

1. Short-term treatment of **active duodenal ulcer**. Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer**. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD)**. Symptomatic relief commonly occurs within one or two weeks after starting therapy. Therapy for longer than six weeks has not been studied.

In active duodenal ulcer, active, benign gastric ulcer, hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: Zantac[®] is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS:

General: 1. Symptomatic response to Zantac[®] therapy does not preclude the presence of gastric malignancy.

2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix[®] may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although Zantac has been reported to bind weakly to cytochrome P-450 *in vitro*, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/d.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella*, *Escherichia coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

Pregnancy: Teratogenic Effects: Pregnancy Category B: Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with Zantac[®]. The relationship to Zantac therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to Zantac administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

Cardiovascular: As with other H₂-blockers, rare reports of arrhythmias such as tachycardia, bradycardia, atrioventricular block, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and rare reports of pancreatitis.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid intravenously for seven days, and in 4 of 24 subjects receiving 50 mg qid intravenously for five days. There have been occasional reports of hepatitis, hepatocellular or hepatocellular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

BRIEF SUMMARY

Zantac[®] 150 and 300 (ranitidine hydrochloride) Tablets
Zantac[®] (ranitidine hydrochloride) Syrup

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia have been reported.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by Zantac and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when Zantac has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Integumentary: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac[®] product labeling).

Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice daily. An alternate dosage of 300 mg or 20 ml (4 teaspoonfuls equivalent to 300 mg of ranitidine) once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison syndrome): The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day. In some patients it may be necessary to administer Zantac[®] 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/d have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

GERD: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac[®] 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac[®] 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30° C (59° and 86° F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac[®] Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 ml in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25° C (39° and 77° F). Dispense in tight, light-resistant containers as defined in the USP/NF.

July 1990



Glaxo Pharmaceuticals

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HELEN M. BAKER RESEARCH FUND

\$40,000 in grants available for research that targets children's lung health, asthma and/or inhaled substance abuse prevention. Application deadline: January 31, 1991.

For more information write:

Central Ohio Lung Association (COLA)
4627 Executive Drive
Columbus, Ohio 43220

Or call: 1-800-592-8563

COLA, a United Way member agency, is NOT affiliated with the American Lung Association.

Medical Aids

Dealing with death and dying

Care for the terminally ill patient may be one of the most difficult tasks of the health-care professional. A new 45-minute, full-color video featuring advice from noted thanatology expert Joy Ufema may provide help, however. The video tells professionals what to say and how to act in common, difficult situations. They also learn how to detect easy-to-miss cues in the patient's conversation. Checklists, tips and conversation starters are featured on such subjects as communication problems, family anxieties, dealing with fears and repressed anger and how health-care professionals can handle their own emotions.

Copies may be ordered from Springhouse Publishing Company, 1111 Bethlehem Pike, Springhouse, PA 19477, or call 1-800-346-7844 to locate a source near you.

Geriatrics: Quality of life

As more and more of your patients reach older and older ages, you may soon find yourself practicing geriatric medicine, whether or not that is your area of expertise. To help you with this inevitable course of affairs is a new book, written by 35 professors from 14 departments at Wright State University School of Medicine, and coedited by Kim Goldenberg, MD and Alice Faryna, MD.

Dr. Faryna says the book is aimed at the physician who treats elderly patients, but who is not a geriatrician. Check your local bookstores, or ask your medical library to order:

Geriatric Medicine for House
Officers
Baltimore: Williams and
Wilkins, publishers



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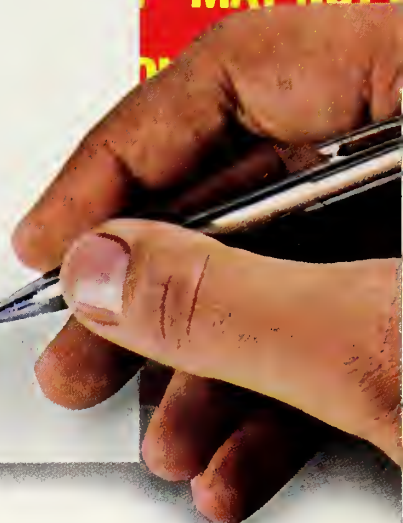
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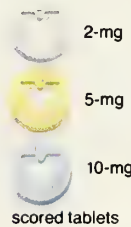
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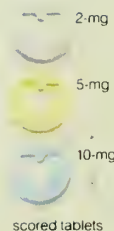
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OHIO Medicine

JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

VOL. 87, NO. 2

FEBRUARY 1991

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Ohio physicians speak out on physician advertising in the 1990s. Cover illustration: "The Quack", copyright 1990 by Rich Muno and Medical Heritage Gallery, Texas. Rich Muno is a representational sculptor who works in both bronze and wood. His sculpture, "The Quack", is derived from the famous set of drawings done by Annibale Caracci and shows a quack doctor practicing his "art" in front of a gullible public in the town square. Medical Heritage Gallery, founded three years ago by Texas physician W.R. Spence, MD, presents works of art from artists of the past and present who have been inspired by ideas, scenes and visions of a medical nature.



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- Enjoy the programs over lunch or coffee.
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Controlling Our Destinies

By John A.
Devany, MD

President of
the OSMA



Item 1: At a recent AMA meeting, C. Everett Koop said that there is a "perception of crisis" by the American people and the media in regards to our health-care system. He said that he had a cab driver say to him that "We need a medical system like Canada's" —

when he asked, what was so good about Canada's system? the driver replied, "I don't know, but it's great."

Item 2: The other night one of our more prominent auxiliaries told me that she asked her husband what he thought of the Canadian system and he said, "*I don't know and I don't give a damn.*"

Item 3: Early in December I spoke to the Riverside Hospital staff in Toldeo on the crisis in health care and I had several family practitioners and pediatricians tell me they have had it up to here with the inability to get proper shots for their babies and children — because the parents can't afford them and when they are referred to the health department their scheduling takes the child well past the recommended age for inoculation — not to mention that the health department has no budget for H. flu shots.

Item 4: The AMA had a modicum of success in getting some anti-hassle legislation through the Congress in regards to Medicare, but this has had no effect on the worsening treatment at the hands of the private carriers. Is it any surprise to hear grumblings that we would be better off with one carrier?

The Coalition for Affordable Health Care is vociferously gearing up for the next legislative session. State Rep. Robert Hagan (D-Youngstown), who introduced the legislation last term, is revising it because the budget office has put an estimate of \$10 billion as an initial cost — remember, the whole Ohio budget is \$26 billion and Gov. Voinovich is going to have to trim \$1.75 billion from that. So it appears that this legislative term will hear a lot of talk, and if a bill is proposed we can expect a public ballot initiative.

Dr. John O'Brien-Bell, during the recent Richard Fulton Memorial lecture, pointed out that if you want to influence the climate in which you will practice, you must invent it. We cannot wallow in ignorance and apathy — typified by items 1 and 2 — we must resist the feeling that we have no control over our own destinies. We have time to become conversant in the multiple issues involved. OSMA already has more than 100 physician speakers lined up to talk to community groups on the problems and the solutions. I am proud of Health Access America. It is a reasonable starting point, it is not self-serving; it is

Continued on page 66

1991 DAY AT THE LEGISLATURE

Sponsored by the Ohio State Medical Association Auxiliary

Wednesday, March 13, 1991 9 a.m. - 3 p.m.

Hyatt on Capitol Square Columbus, Ohio

\$25 per person

Includes Continental Breakfast and Lunch

FEATURING:

POLITICAL ANALYST:

Charles E. Cook, Jr., political analyst and consultant; Vice President in the Strategic and Economic Analysis Division of Hill and Knowlton Public Affair Worldwide Co.; and editor of the *Cook Political Report*.

OHIO LEGISLATIVE LEADERS:

Sen. Grace Drake (R-Solon), Chair of the Ohio Senate Health and Human Services Committee.

Rep. Paul Jones (D-Ravenna), Chair of the Ohio House Health and Retirement Committee.

RECEPTION AND LUNCH WITH STATE LEGISLATORS:

An excellent opportunity for physicians and their spouses to discuss their concerns with their personal legislators from the Ohio Senate and Ohio House of Representatives.

WORKSHOP:

Ohio Auxilian participants of AMPAC Campaign School.

Room Reservations: Contact the Hyatt on Capitol Square at (614) 228-1234. Identify yourself as being with the OSMA Auxiliary. Rates: \$89 single, \$99 double. Deadline for room reservations: March 1, 1991.

Make check for \$25 per registrant payable to: Ohio State Medical Association Auxiliary

Send check and registration form to: OSMA Auxiliary, 1500 Lake Shore Drive, Columbus, OH 43204-3824

Deadline for Registration: March 3, 1991

Name _____ Check One: ☐ Physician ☐ Auxilian

Address _____ ☐ Student ☐ Guest

City _____ ZIP Code _____

County you are representing _____

I understand an invitation has been extended to the legislators by Sue Massie, OSMA-A President, and the OSMA Legislative Committee, but I will personally contact my Senator/State Representative to attend.

Senator/Representative: _____

Legislation Key to Progress

The greatest opportunity for changing the climate in which physicians practice medicine rests with our legislative efforts. Being informed and keeping our legislators informed as

well about what impact proposed health legislation can have on the people of this state and the nation is critical. Medical technology is advancing at such a rapid pace that it is often mind boggling —

even to the medical community. The research and new medical knowledge are bombarding us so quickly that there is hardly time for proper experimentation before the public is seeking use of curative measures incorporating the latest and most promising advances.

When life-threatening situations arise, any compassionate person wants to do everything in his power to affect positive results. Due to the urgent nature of medical care for illnesses and diseases, the public can be overanxious to find a cure or solution. As a result, pressures are exerted to bring about changes that will ensure certain actions are taken. Well-meaning legislation is sometimes introduced that can

have devastating long-term repercussions.

Physicians must look beyond the emotional need to affect a quick and easy solution to an immediate problem and examine the future ramifications.

The OSMA Auxiliary has made great strides in becoming informed regarding legislative issues and in taking an active part in keeping our physician spouses informed as well. The Auxiliary's "Day at the Legislature" is a good example of the contribution that the Auxiliary can make to ensure that health legislation that is in the best interests of the people of the state of Ohio will become a reality.

We extend an invitation to physicians, medical students and guests to join auxiliaries across the state as we learn together about the legislative process, pending health legislation, about our personal legislators, and what auxiliaries have learned about the political process. An exciting day has been planned for physicians, auxiliaries, medical students and their spouses and guests.

Mark March 13 on your calendar, and plan to be with us at the Hyatt on Capitol Square in Columbus for the Auxiliary's "Day at the Legislature." Use the registration form in *OHIO Medicine*. We'll look forward to seeing you there. Being informed is the important first step. Together we can make a difference legislatively. **OSMA**

By Sue Massie

OSMA Auxiliary
President



A MULTIPLE CHOICE QUIZ

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- D.** Statewide seminars on issues and procedures;
- E.** Provider Relations representatives throughout Ohio who make "house calls";
- F.** Availability of an electronic claims submission network, to streamline office efficiency;
- G.** All of the above.

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Journal Gets Facelift

The Advisory Committee of *OHIO Medicine* takes delight in introducing a new direction for our monthly journal—a journal that is intended for you! Last year under the direction of William Marshall, MD, the OSMA Council charged the

Advisory Committee to come up with a trim and sleek monthly issue designed to provide the practitioner with information that will be useful to an active practitioner and that is

not readily available elsewhere.

After considerable debate the committee decided to publish articles that were practical and easily readable. The strategy will be to strive to present articles of socioeconomic subjects in a compact format that will rarely occupy more than one or two pages of print. Several of the features that will be forthcoming on a regular basis will be: a legislative article prepared by the Legislative Department of OSMA, a legal series prepared by the legal councilors that are retained by the OSMA, selected subjects on the working of the PRO and prepared by their office, guest editorials of timely and controversial subjects,

and, we hope, an active interchange of ideas from members of the OSMA—that is, from physicians like yourself—in a letter to the editor column.

The Editorial Committee will strive to be selective and critical of all future articles prior to publication. Any submitted material will be scrutinized by each member of the committee and only honest, objective and non-self-serving articles that will augment the principles of the OSMA will be published. At the same time, items of a controversial nature will be welcomed and published if they will generate constructive thought and criticism.

We have made a difficult decision in no longer accepting scientific articles. The readership has told us that such articles are rarely read and often do not represent the best in their field. From time to time the committee will solicit scientific articles if it is felt that a subject would be especially useful to Ohio physicians and not readily available in the specialty journals.

OHIO Medicine is your monthly guide to the “happenings” in medicine within the state of Ohio. We need your support and advice as to the best method that we can achieve this goal. Just as letters to Congress are very effective . . . we assure you that your letter will be effective. **OSMA**

Richard B. Reiling, MD is chair, Advisory Committee, OHIO Medicine.

**By Richard B.
Reiling, MD**





CENTER FOR CONTINUING MEDICAL EDUCATION PRESENTS

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- prevention of pre-term birth and evaluation of the at risk patient for fetal genetic disorders
- strategies for risk management in the high risk pregnancy

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11.25 hours in Category I of the Physician's Recognition Award of
the American Medical Association

Application has been made to Ohio Nurses Association and the
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For a conference brochure or more information, please contact The Ohio State University Center for Continuing Medical Education at
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Filing Medicare Claims Electronically

If you're a physician who sees Medicare patients — even if that number is as low as one or two a year — you should be looking at ways you can file your claims electronically.



Why?

Previously, the biggest incentive was the regulation considered by Congress and the Bush Administration that would have charged physicians \$1 for each paper claim they filed. Now that this proposal is dead (at least for the moment), other reasons have taken its place.

The biggest reason to consider electronic claims submission, of course, is faster turn-around time.

Jeff Dayton, Medicare's resident electronic submissions expert with the lengthy title Electronic Media Claims Technical Division Manager, says, "If I receive a claim in my office today, I could

process it tomorrow."

Keep in mind, however, that a 14-day payment floor *still* applies (even to electronic claims) and payment may not be released prior to the 15th day. This may eventually change. Congress is looking to reduce electronic claims payment to 11 days and increase hard-copy claims to 17 days, so there is an ever-growing incentive for physicians to make the switch to electronic claims submission.

Basically, there are three ways to file claims electronically with Medicare — by a magnetic 9" tape or 8" diskette, or by a dial-up modem. According to Dayton, the magnetic tapes are more susceptible to physical damage and loss while submission of claims via a modem is more reliable and potentially less time-consuming.

Medicare supports two types of modems, the Bell Standard 208 A/B and the CCITT Standard V.22 Bis. Dayton points out that other 4,800-bits-per-second and 2,400-bits-per-second modems exist, but that physicians should be careful when purchasing these because not all modems of the same speed are compatible. A Bell 208 A/B modem costs about \$1,500; a Bis modem will run

Reimbursement

about \$550. In addition to the modems, a Bisynchronous 3780 emulation card must also be purchased. This card costs about \$900, and according to Dayton, "along with its peer at Medicare will provide the error-free transmission that is needed when sending financial information accurately across the phone system."

Physicians should be aware, however, that this card may not provide the same error-checking capability with other computer systems with which they may be linked. In other words, at least for the moment, that \$900 card you purchase may only work with Medicare's system. The industry is moving gradually toward standardization, but until that is achieved physicians are going to have to deal with each carrier on an individual technical basis.

That's one of the frustrations physicians who purchase equipment for electronic claims filing express. Another frustration is the fact that computer technology changes so rapidly. Yet trying to stay on the cutting edge of computer technology is much like hospitals or physician offices attempting to stay on the edge of medical technology. Something better always seems to be on the drawing board.

Dayton says that once the hardware is in place, it is relatively stable, and any changes that *are* needed are typically dictated by business needs. Still, before purchasing a system, it is advisable that you buy from reputable dealers of good standing and proven longevity, and that you look into any maintenance-service agreements that the dealers may have available. After all, changes



**Congress is looking
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so there is an
ever-growing
incentive
for physicians to
make the switch . . .**

are almost inevitable, and you're going to want to deal with a company that is still going to be around when those changes occur.

If you're unsure of the system you are about to purchase or how well it will function in filing Medicare claims, call Dayton (614) 249-4922. Not all systems are going to be compatible with Medicare's, and the time to find this out is before you buy — not after.

Once your system, modem, 3780 card and software has been purchased, there is a testing period that must be followed within Medicare prior to sending any live claims. The start-up time isn't lengthy, but you should know that it's there. This upfront testing, says Dayton, ensures better service later, when your transmission is approved and you go "live."

Generally, once physicians come on board, they realize that filing electronically is easier than they thought. Besides, there is little doubt that electronic filing is becoming a major way of conducting business in today's technologically oriented world. The sooner the plunge is taken, the sooner physicians can ensure that their offices stay up-to-date in the years ahead. **OSMA**

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Columbus, Ohio

In consideration of payment of the premiums, we agree to provide coverage protection against professional liability claims which are brought against you in your practice as a physician or surgeon. We rely on the state boards and agreements you make in re: application for coverage and as a result those agreements and agreements you sign with this agreement.

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This is an **Occurrence Policy**. Your coverage is limited to liability for only those damages arising out of **MEDICAL INCIDENTS** which occur during the **COVERAGE PERIOD** as shown on the Co-

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This policy also seems smart as it fits during the COVID-19 pandemic as a representation of the activities of another person who is not a **PROXIMATE MEDICAL SERVICE** is not a patient of one who is legally responsible for the acts or omissions of the other person. Hence, this policy does not restrict the medical liability of the persons who are responsible.

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Exclusions (What This Policy Does Not

1. Any highlight or amendment pertaining to the above objectives shall be submitted to the committee for review and approval.



Today, with stringent new requirements for reporting *any payment which results from a malpractice settlement* to a federal data bank, protecting our policyholders is more important than ever.

Ohio Medi-Scene

Helmets required for bike riders

In the Cleveland suburb of Beachwood, the City Council recently passed the state's first ordinance requiring bicycle passengers and riders under age 16 to wear helmets while cycling on public property.

After spinning its wheels for three months the council passed the bill 4-0, with two members abstaining.

During the months of debate, some officials felt that an education program would be more appropriate than actually putting a law on the books. However, an education program this fall in Howard County, MD, failed to stop two youngsters there from riding without helmets and being killed in an accident. That incident helped sway the ordinance vote.

Bicycle accidents kill approximately 1,200 Americans a year, about half of them children, according to the American Academy of Pediatrics. Helmets reduce the risk of serious head injury by 85%, according to Michael Macknin, MD, a Beachwood member of the Academy who lobbied heavily for the ordinance.

If a youngster fails to obey the ordinance, the law holds his or her parent or guardian responsible and will fine parents up to \$25 for a violation.

The city police chief admits they will be dealing with children and do not intend to traumatize them so warnings will be given to first-time offenders. On a more drastic note, in some instances bicycles with be confiscated.



Ohio hospitals seek low-cost waste disposal

In 1986, disposing of infectious waste cost Ohio hospitals less than \$100,000. By 1989, that figure jumped to \$8 million.

Infectious waste disposal has become such a high-ticket item, in fact, that more and more hospitals in the state are exploring alternate disposal methods.

The Greater Dayton Area Hospital Association, for example, has formed a task force that is studying the problem, which intensified last spring when new state regulations prevented the hospitals from burning their waste at a local incinerator for 1¢ a pound. Since then, hospitals have had to pay a private hauler 26¢ to 43¢ a pound to haul the waste. The task force is expected to recommend a long-term solution soon.

Options include building a special waste incinerator, constructing a special microwave facility to shred and disinfect the

waste, or expand units at the hospitals in which the material is disinfected by steaming. Or, hospitals can contract with a waste hauler as a group in hopes of bringing costs down. Presently, 71% of Ohio hospitals have their wastes hauled away — which amounts to about 2,000 tons a year. Waste products include needles, syringes, bandages, lab dishes, rubber gloves and other hospital equipment. **OSMA**



Ohio Medi-Scene

Ex-coke moms-to-be will receive phone calls to keep them drug-free

A talking computer may be just what pregnant women who have quit using cocaine need to keep themselves and their unborn babies drug-free.

Two researchers at Cleveland State University received a \$2.7 million national grant for a computerized telephone project aimed at reducing the number of cocaine-addicted babies born in Cleveland.

According to researchers, the computer will call the women frequently to remind them of doctor appointments, ask questions about their health or give advice. A nurse will be called if something seems out of the ordinary. The women may also call the computer to ask for help on particular problems.

The study will begin enrolling participants next October. No more than 150 will be selected. At the project's conclusion in four years, the women's drug use, health and health of their children will be compared to a group of similar women who did not converse with the computer.

Although researchers have high hopes for the program's success and expect a national impact to be made, others remain skeptical.

The manager of a cocaine hot line, who is a recovering cocaine addict said, "I don't think a telephone call would make a person responsible." **OSMA**



Homelessness creeps into Ohio's rural counties

Physicians practicing in Ohio's rural counties could see as many as 20,000 homeless people this year — nearly triple the number from six years ago.

The estimate comes from a new study conducted by Ohio State University researchers who are calling it the most thorough study of rural homelessness ever undertaken. Included in the study were Clermont, Brown and Preble counties in southwestern Ohio.

A statistical picture of the typical homeless person in rural communities was drawn from the data collected. Most are young. The average age is 29, and 78% are between 18 and 39. Nearly 52% were females, half of whom had children. More than half of this group were high school graduates and disproportionately a member of a minority group.

Researchers cite today's economy, changes in family structure, a high-tech labor market and scarce housing as reasons for the surge.

Few of the professionals who

work in this area believe the situation is going to improve in the future without significant changes. However, the state homeless coalition plans to launch a project this spring that will be aimed specifically at rural areas and smaller cities. **OSMA**

Medical school never taught you this one . . .

He couldn't blame it on the bossa nova, so prisoner John White decided instead to lay it on the lambada, that sensual South American dance that has found its way onto dance floors considerably north of the equator.

In an attempt to avoid enforcement of an 18-month prison sentence, White recently offered a letter, purportedly from his physician, to Judge Frederick McDonald in Lucas County Common Pleas Court.

The letter, typed and professionally presented, contended that White suffered from numerous back ailments, including a bruised "lambada."

While the fiery dance might conceivably *create* a few bruises, Judge McDonald had serious concerns about the letter's legitimacy. He called for a recess.

White, suspecting the judge was about to verify the letter, slipped quietly from the courthouse.

He was back the next day to admit the letter had not come from a physician (no surprise there), and to apologize. Judge McDonald ordered the prisoner to immediately begin serving a sentence that had been delayed since May for medical reasons. Apparently *those* reasons had been valid. **OSMA**

Ohio Medi-Scene

No more tax break on "elective" cosmetic surgeries

This is the year Congress has made elective cosmetic surgery ineligible for medical tax breaks under its new tax plan — but there still seems to be some debate as to what constitutes "elective" surgery.

The new regulation is intended to apply to purely cosmetic surgery, and not to surgery meant to correct deformities which arise from birth defects, accidents or disfiguring diseases. The new rules are expected to save the U.S. Treasury about \$270 million over the next five years.

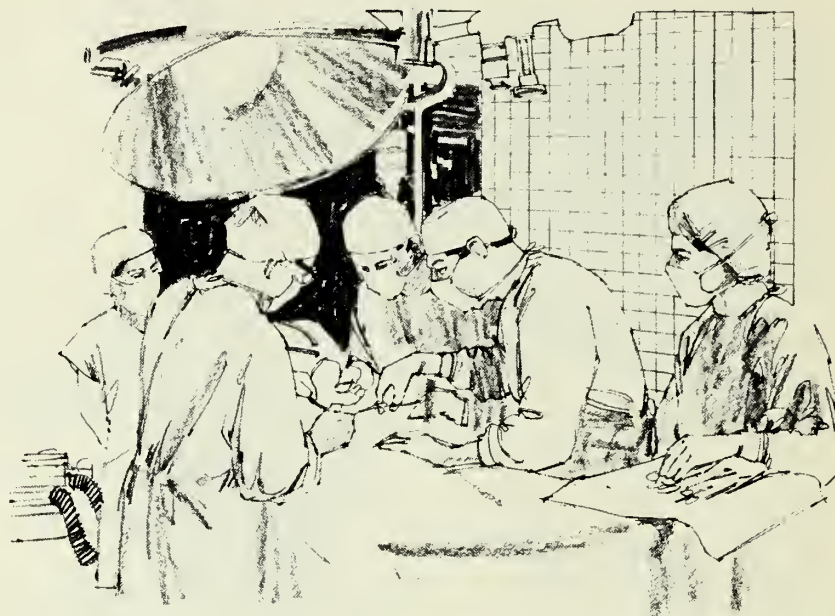
The debate comes over the matter of breast reconstruction. Under the current definition, breast augmentation or liposuction would not be eligible for tax breaks. However, mastectomy-related surgery would continue to be covered. **OSMA**

Ohio HMOs decrease in number

Three years ago, Ohio hosted 47 health maintenance organizations. Presently, that figure stands at 32, the result of failures and mergers. Seven HMOs are under state supervision.

About 1.5 million Ohioans are HMO members, but whether or not that figure will increase in the 1990s will depend on the marketplace.

As one HMO official points out, the marketplace is still a competitive one, and HMOs will have to prepare now for any changes that will occur over the next decade if they hope to survive. **OSMA**



Colleagues

Ralph A. Straffon, MD, chief of staff at the Cleveland Clinic Foundation, is the new president-elect of the 50,000-member American College of Surgeons. His appointment was announced at the ACS's annual meeting in San Francisco. He will be installed as president in October 1991.



Straffon

A member of numerous professional organizations, Dr. Straffon has served as a regent of the American College of Surgeons since 1980. He is past president and trustee of the American Board of Urology and former president of the American Association of Genitourinary Surgeons.

Stewart B. Dunsker, MD, Cincinnati, has been elected vice president of the American Academy of Neurological Surgery

for 1990-91. A past president of the Ohio State Medical Association and a neurosurgeon with the Mayfield Neurological Institute since 1970, Dr. Dunsker is one of a select group of 100 prominent neurosurgeons throughout the world who belong to the American Academy of Neurological Surgery.



Dunsker

In addition to his neurosurgical practice, Dr. Dunsker serves as professor of clinical neurosurgery and director of the spine division of the Department of Neurosurgery at the University of Cincinnati Medical Center. He is also the director of the Department of Neurosurgery and co-director of the Spine Institute at the Christ Hospital. **OSMA**

Ohio Medi-Scene

Colleagues

D. Ross Irons, MD, Bellevue, received back-to-back honors for accomplishments both in and outside the field of medicine.



Irons

Dr. Irons, a past president of the OSMA, was recently presented with the Ohio State University's College of Medicine "Alumni Achievement Award," presented each year by the Medical Alumni Society at its annual Alumni Reunion. The award honored Dr. Irons' activity at the local, state and national levels of organized medicine.

In addition, Dr. Irons has been inducted into the Ohio Northern University Athletic Hall of Fame for his four years of accomplishments in both varsity football and track and field.

Ronald B. Berggren, MD, Columbus, professor emeritus of surgery at the Ohio State University College of Medicine, has received the



Berggren

Distinguished Service Award of the Plastic Surgery Educational Foundation, the highest honor given by the Educational Foundation. Dr. Berggren has served as the president of the foundation, and has chaired both the American Board of Plastic Surgery and the Accreditation Council for Graduate Medical Education.

Dr. Berggren was director of the Division of Plastic Surgery at Ohio State's College of Medicine from 1965 to 1985, and was director of the Division of Plastic Surgery at Children's Hospital in Columbus from 1965 to 1990.

Clinical Clips

8.6%

The percentage of increase in medical school applications in 1990

25.4%

The percentage of increase in female medical school enrollment in the past 10 years

4,076

Number of black medical students enrolled last year

3,518

Number of Hispanics enrolled last year

1,102

Number of AIDS fatalities in Ohio in 1990

1,868

Number of total cases in Ohio in 1990

78,340

Number of AIDS fatalities in the U.S. in 1990

128,319

Number of total cases in the U.S. in 1990

\$15,000

The amount of increase in U.S. doctors' salaries in 1989

\$87,000

Annual income for general practitioners

\$296,000

Annual income for cardiovascular surgeons

6%

Percentage of physicians who make less than \$50,000 annually

\$36,000

Amount of increase in obstetrician's pay

10.1

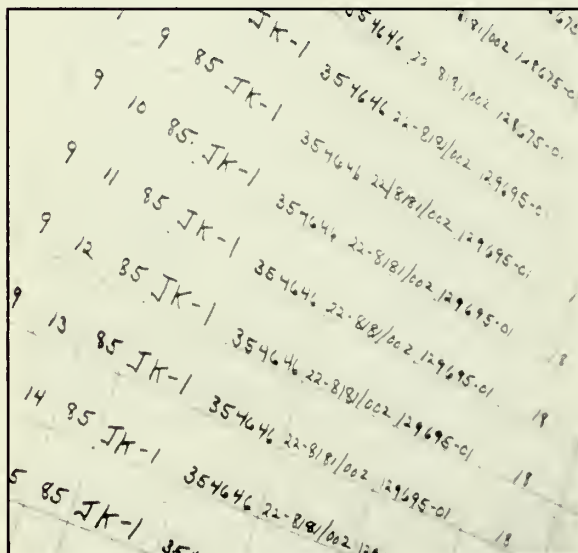
The number of deaths in the first year of life for every 1,000 births in the U.S.

Sources on page 65

Medical Records Must Go With You

Editor's note: *Sooner or later, every practicing physician faces the prospect of retirement. To help doctors prepare for the inevitable, we are launching a series of articles in this department that will address topics of interest to the retiring physician or the one thinking of retirement. The articles will rotate every other month with features planned to help new physicians start a practice. That series will debut next month. Once*

these two series are completed, this section will be used to cover other issues of interest to practicing physicians — no matter which end of the spectrum they occupy.



medical records. What should you do with them?

The answer is one of two things. You can collect the records, throw them in the back of your car and take them home with you. Or, you can find a custodian to care for the records for you (more on this later). The bottom line, however, is that you keep them. How long?

"Indefinitely," says Scott Clapp, JD of the OSMA's Department of Legal Services. "Officially, records can be disposed of at least one year after your death or the death

of the patient."

The time limit is not arbitrary. It's determined by Ohio's statute of limitations for filing medical liability claims, which was expanded several years ago by the Ohio Supreme Court. The one-year statute of limitations does not begin to run until the latter of:

a.) The termination of the physician/patient relationship for the particular illness, or injury ends; or

b.) When the patient becomes aware, or should have been aware, that a condition was related to a specific professional medical service previously rendered; and whether such condition would put a reasonable person on notice of need for further inquiry into the cause of the condition.

Without your *original* medical records in hand or, at least, accessible, your defense in any malpractice case would be difficult, at best. Be sure when you forward copies of a patient's medical records on to his or her next physician, they are just that — copies. Retain your original records. (Incidentally, you may charge the patient a reasonable fee for copying the records.)

Be sure, too, before forwarding the records, that you have a *written* request from the patient asking you to do so.

"The patient needs to release the records," says Clapp — and that applies whether you're simply closing your practice, or selling it.

"You don't sell the records with the practice," Clapp continues. "They should remain your property."

On the other hand, a physician

Law

who has formerly treated a patient should not refuse for any reason to make the records promptly available on request.

"Records should not be withheld for failure of payment by a patient," says Clapp.

Of course, the prospect of retaining and storing all of these records can be burdensome, especially if your retirement plans include moving to a smaller space or changing your location frequently. That's where a records

custodian may be a convenience.

The custodian can be a physician or non-physician who agrees (usually for a fee) to retain your records for you. This custodian would not have access to the content of the records — however they *could* make and transfer copies with written authorization from the patient.

There are companies now that will serve as custodian of your records (and even put them on microfilm for you), and groups,

partners and even hospitals may be willing to serve as your record custodian.

"We generally recommend the custodian be another physician, if possible, because he or she will understand the issue of patient confidentiality," says Clapp.

When time comes for the records to be destroyed, burn them or shred them. Confidences rarely stay that way if they're simply dropped into a Dumpster. **OSMA**

The Medical Records of Minors

If you are a retiring pediatrician, you may be tempted to destroy the records of your minor patients. Don't, cautions Scott Clapp, JD, of OSMA's Department of Legal Services.

"Even pediatricians should plan on maintaining their patient's records indefinitely," he says.

Despite the fact that records of minors, according to current law, need only be maintained until the patient reaches the age of majority (18 years) plus four years after that, malpractice suits may still be brought against physicians under the statute of limitations ruling.

Consequently, you are advised to keep all records — even those of patients you treated as minors who have now come of age. **OSMA**



Sources for Clinical Clips

Medical school enrollment	<i>USA Today</i> October 23, 1990
Women in medical schools	<i>Cincinnati Enquirer</i> August 15, 1990
Number of AIDS cases	<i>Toledo Blade</i> May 8, 1990
Doctors' incomes	<i>Dayton Daily News</i> September 24, 1990
Infant mortality rate	<i>Cincinnati Post</i> August 6, 1990

Presidential Perspectives . . . continued

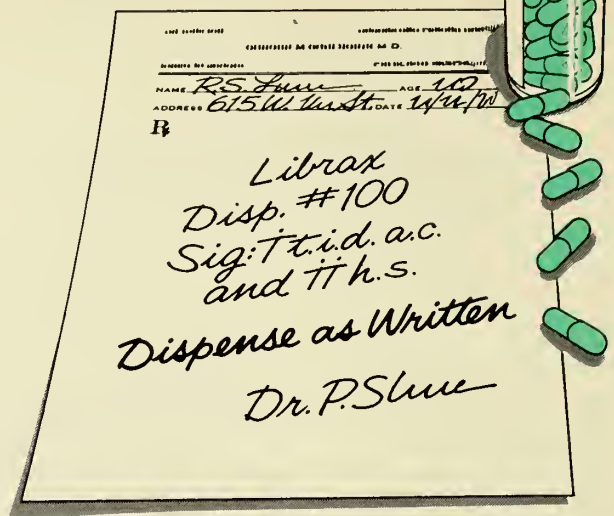
doable.

We must not let our own frustration blind us to the fact that the government is interested only in the bottom line. It gives lip service to quality, which I suppose is somewhat better than the private carriers, which wish to force us to be responsible for quality through supervision, education and management but not pay for it, e.g. the pathologist's suit against Blue Cross/Blue Shield.

Let's take one little aside in this column, because for six weeks I tried to find out where Uwe Rinehart got such a figure, as he keeps stating in *USA Today* and the *Wall Street Journal* — that Medicare's administrative costs are 3%. I know of no one who has any dealings with Medicare who believes that — certainly when you see the huge, new insurance buildings filled with Medicare computer systems, not to mention the costs that are thrust upon the physicians by law to prepare the forms and even threatening with a charge for filing them. As near as I can find out, that 3% refers to the fact that Medicare says it costs them \$3 to process a claim. Those two figures do not mean the same thing, Uwe, ol' boy.

When I go around talking on the health-care crisis I am reminded of the old song, "Is You Is or Is You Ain't My Baby?" I think we all better start looking at this problem very carefully before we find him on our doorstep. OSMA

Specify Adjunctive **LIBRAX**®



Each capsule contains 5 mg chlorthalidone HCl and 2.5 mg clidinium bromide.

Please consult complete prescribing information, a summary of which follows:

- * **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
 "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
 Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlorthalidone HCl and/or clidinium Br.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur. Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlorthalidone HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlorthalidone HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlorthalidone; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

P.I. 0288



Roche Products

Roche Products Inc.
Manati, Puerto Rico 00701

OH

To insist on
the brand,
be sure to
write
"Dispense as
Written"
or "D.A.W."
on your
prescription.

In IBS,* when it's brain versus bowel,

**IT'S TIME
FOR THE
PEACEMAKER.**

In irritable bowel syndrome,* intestinal discomfort will often erupt in tandem with anxiety—launching a cycle of brain/bowel conflict. Make peace with Librax. Because of possible CNS effects, caution patients about activities requiring complete mental alertness.

*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of peptic ulcer and IBS.

Specify Adjunctive

LIBRAX[®]

Each capsule contains 5 mg chlordiazepoxide
HCl and 2.5 mg clidinium bromide.

ROCHE

Physician Advertising

Ohio Physicians Speak Out After a Decade of Change

In the beginning, there was hucksterism — herbal potions and strange concoctions — sold from the back of wagons by charlatans to an unsuspecting public.

Then, in 1847, the American Medical Association was formed, in part to prohibit the kind of activities described above. Even at that early date, the AMA was concerned with setting high professional standards, as well as a code of ethics for the practice of medicine.

Consequently, medicine grew up with a distaste and discomfort for advertising. For years, self-promotion or marketing of any kind, beyond a business card and a Yellow Pages listing, was frowned on by medical societies and professional groups across the country.

Then came the 1980s and government's strong insistence that medicine not engage in any activity that might be construed as anti-trust. In fact, about the middle of that decade, the federal government was quite explicit in stating that it was illegal for any organization or state to prohibit

physicians and other professionals from advertising.

Shortly after that announcement, Ohio, as well as other states, began to see a proliferation of physician and hospital marketing companies spring to life. The way had been paved for physicians to go beyond the business card and Yellow Pages listing, and there were any number of experts happy to help physicians, who were both naive and wary of advertising, compete in an increasingly competitive world.

Now, of course, it's the 1990s, and physicians, often hand in hand with their marketing experts, have become more knowledgeable and more sophisticated about the methods, tools and necessity of self-promotion. Have they become more comfortable with it?

To a large extent, it depends on whom you ask. That's why we've gathered a number of opinions on the subject, from physicians in all types of practice, all over the state. Sometimes, the best way to gauge your own feelings on a subject is to listen to what others in your position think. Some embrace the



concept of advertising in its every nuance. Others seem to shun it.

No matter what your own personal philosophy on advertising — or that of others — may be, however, there are certain laws and guidelines that must figure prominently in any discussion on the subject. For that we've included a sidebar that expresses the views of the AMA on the subject, as well as guidelines on what constitutes *ethical* advertising.

Physician marketing and advertising is now nearly a decade old. As the '90s continue to unravel, it will be interesting to keep track of the changes a new decade brings. One factor remains constant, however, and that's the fact that physician advertising is here to stay. Like it or not, it's become an essential part of today's changing medical scene.

William H. Havener, MD Columbus

"A sick and frightened patient is uniquely vulnerable to unscrupulous manipulation. Advertising in medicine (can) result in excessive and inappropriate care."

Susan L. Hubbell MD Lima

"I don't advertise, and I worry that the public may become excited about a practitioner based on an ad alone. That physician, however, may not be the *best* physician."

James G. Ravin, MD Toledo

"Which of the following should we believe?

'Advertisements contain the only truths to be relied on in a newspaper' — Thomas



**"Marketing is a means
of engineering satisfaction.
We try to offer patients
what they want and
need. But today's
wants and needs may
not be the same as
tomorrow's. That is part
of the challenge."**

James G. Ravin, MD

Jefferson

'You can tell the ideals of a nation
by its advertisements' —

Norman Douglas

'Freedom! To spit in the eye and
in the soul of the passerby and
the passenger with advertising'
— Alexander Solzhenitsyn

"We have all seen doctors turn
to testimonial ads on television
and large display advertisements in
the Yellow Pages. The physicians
using these techniques obviously
have felt they were proper for them
at the time. Would these methods
help us? At the present cost? If
available at no cost? So far in our

practice we have not felt these
items would be of big benefit to
us.

"But what form of marketing
would work? Discounts? Free
transportation for all? Magnetic
stick-ons for the refrigerator?

"Marketing is a means of
engineering satisfaction. We try to
offer patients what they want and
need. But today's wants and needs
may not be the same as
tomorrow's. That is part of the
challenge."

Theodore E. Wymslo, MD Dayton

"I advertise in the Yellow Pages
and White Pages — just a very
basic ad. I only do this to let the
patients know how to reach me. I
don't feel it leads to *new* patients
for my practice. I also think
physicians should police their own
ads to be sure that the public is
not misled by them."

Michael Stark, MD Sylvania

"My comments are based only
on my opinion, and not necessarily
on that of my group or the
Academy of Medicine of Toledo
and Lucas County, of which I am
currently vice president.

"We know that physician or
hospital advertising is not
unethical and cannot be considered
improper. However, I have always
taken exception to the premise that
people will and should choose
their physicians based on
marketing techniques. My
particular group of general
surgeons has never engaged in
advertising and there are no plans
for the future to undertake such
an endeavor. I have always felt
that people should choose their

physicians based on recommendations from other physicians or their primary care physician and/or friends who have had personal experience with certain physicians. As many people do not have private physicians, I believe that the hospital physician referral sources can serve this function. Also, we encourage people to contact the local academy of medicine for physician referral under these situations.

"I have also had concerns about hospital advertising, as I feel this does consume a significant portion of the health-care dollar. Again, I believe that patients should choose their hospitals based on recommendations from their personal physician and not by radio, television, billboard and



"I have always felt that people should choose their physicians based on recommendations from other physicians or their primary care physician and/or friends who have had a personal experience with certain physicians."

Michael Stark, MD

newspaper advertisements.

"However, I do believe that medical advertising is here to stay. I believe that hospitals have found

it to be profitable and I believe that certain physician groups have also found it to be profitable. One need only look at the Yellow Pages

OLD STRENGTHS NEW VISION

Turner and Shepard combines the stability and experience of more than 40 years in business with a youthful, new management group dedicated to finding cost-efficient solutions to your insurance needs. Turner and Shepard and your OSMA... making affordable the benefits you need.



TURNER & SHEPARD, inc.

17 South High Street, Columbus, Ohio 43215 614 228-6115

telephone directory in most of our large communities. I do believe, however, that there should be some truth in advertising. I believe that physicians must represent themselves honestly and should not claim to be specialists in areas in which they do not have specific training. I do believe that being Board-certified represents an important credential. It may indeed be an appropriate function of the local county medical society to ensure truth in advertising of its colleagues. We certainly know that the Yellow Pages directory does not claim to carry out this function. Since advertising is here to stay and likely will increase in the future, I believe that the advertisers need to be responsible for their claims."

Mark DeMichiei, MD
Toledo

"I do not advertise, other than a listing in the Yellow Pages. I do not intend to do anything more than that and a listing for our office (corporation). I have seen advertisements that indirectly promise almost perfect results. In view of that, it's no wonder why (these physicians) get sued."

Philip G. Wilcox, MD
Akron

"I don't advertise, and I don't believe that a physician should advertise himself or herself as a self-proclaimed expert. A physician's performance, accessibility and patient rapport is his or her best advertising."

Charles A. Peter, MD
Toledo

"Physician advertising is here to stay.

"Most physicians advertise even though they may not realize it or even consider their advertising as true advertising. Almost all physicians have listings in the yellow pages which may be small or large. They feel that they have to advertise because everyone else is. There have been several studies to show that the only thing that physician advertising does is raise the cost for the patients. The physicians best advertisement is a happy and satisfied patient.

AM Confiden and Con

5.01 ADVERTISING AND HMOs.

A physician may provide medical services to members of a prepaid medical care plan or to members of a health maintenance organization which seeks members or subscribers through advertising. Physicians practicing in prepaid plans or HMOs are subject to the same ethical principles as are other physicians. Advertising that would lead prospective members or subscribers to believe that the services of a named physician who has a reputation for outstanding skill would be routinely available to all members or subscribers, if in fact this is not so, is deceptive. However, the publication by name of the roster of physicians who provide services to members, the type of practice in which each is engaged, biographical and other relevant information is not a deceptive practice. (II,VI)

5.02 ADVERTISING AND PUBLICITY.

There are no restrictions on advertising by physicians except those that can be specifically

justified to protect the public from deceptive practices. A physician may publicize himself as a physician through any commercial publicity or other form of public communication (including any newspaper, magazine, telephone directory, radio, television, direct mail or other advertising) provided that the communication shall not be misleading because of the omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive.

Because the public can sometimes be deceived by the use of medical terms or illustrations that are difficult to understand, physicians should design the form of communication to communicate the information contained therein to the public in a readily comprehensible manner. Aggressive, high-pressure advertising and publicity should be avoided if they create unjustified medical expectations or are accompanied by deceptive claims. The key issue, however, is whether

Source: Current Opinions, T

Opinions on Integrity, Advertising Communications Media Relations

advertising or publicity, regardless of format or content, is true and not materially misleading.

The communication may include: (a) the educational background of the physician; (b) the basis on which fees are determined (including charges for specific services); (c) available credit or other methods of payment; and (d) any other nondeceptive information.

Nothing in this opinion is intended to discourage or to limit advertising and representations that are not false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act. At the same time, however, physicians are advised that certain types of communications have a significant potential for deception and should therefore receive special attention. For example, testimonials of patients as to the physician's skill or the quality of his professional services tend to be deceptive when they do not reflect the results that patients with conditions comparable to the testimoniant's condition generally receive.

Statements relating to the quality of medical services can raise concerns because they are extremely difficult, if not impossible, to verify or measure by objective standards. However, objective claims regarding experience, competence and the quality of the physician's services may be made if they are factually supportable. Similarly, generalized statements of satisfaction with a physician's services may be made if they are representative of the experiences of that physician's patients.

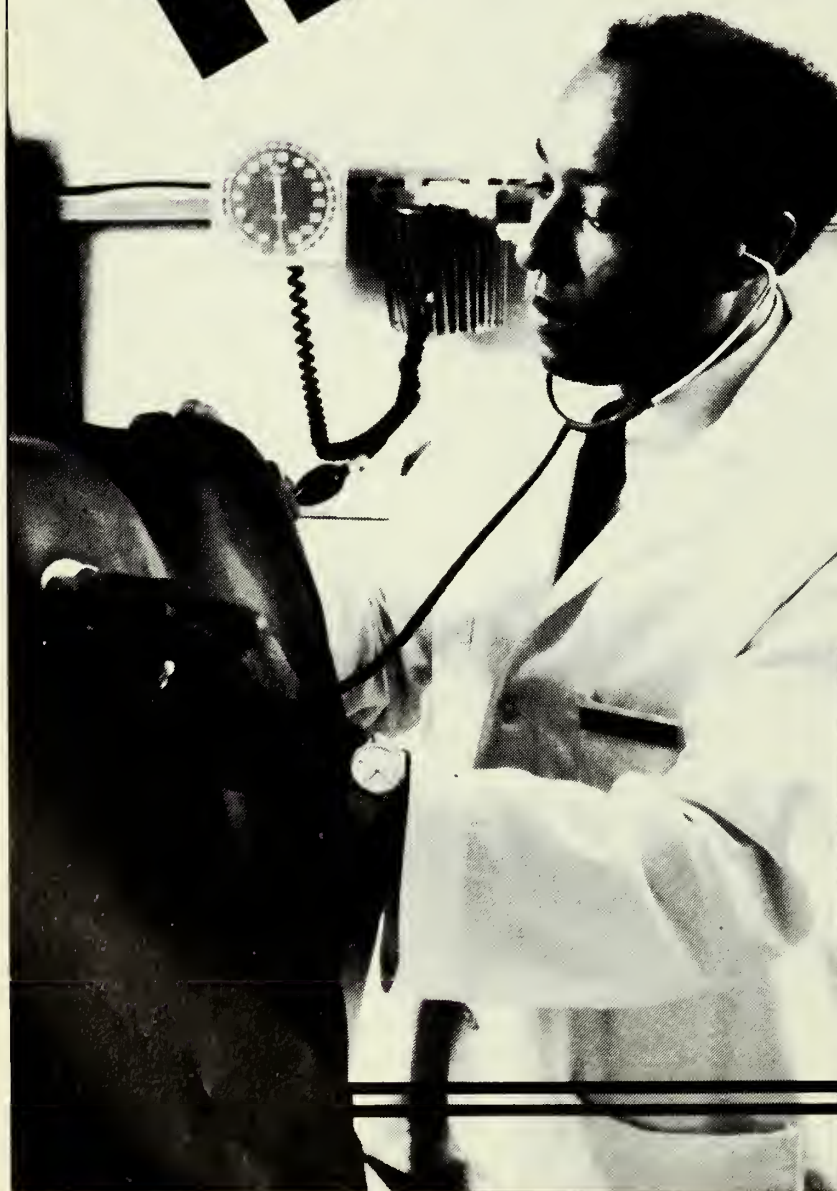
Because physicians have an ethical obligation to share medical advances, it is unlikely that a physician will have a truly exclusive or unique skill or remedy. Claims that imply such a skill or remedy therefore can be deceptive. Statements that a physician has an exclusive or unique skill or remedy in a particular geographic area, if true, however, are permissible. Similarly, a statement that a physician has cured or successfully treated a large number of cases involving a particular serious

ailment is deceptive if it implies a certainty of result and creates unjustified and misleading expectations in prospective patients.

Consistent with federal regulatory standards that apply to commercial advertising, a physician who is considering the placement of an advertisement or publicity release, whether in print, radio or television, should determine in advance that his communication or message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser, and those that a reasonable, prudent advertiser should have discovered. Inclusion of the physician's name in advertising may help to assure that these guidelines are being met.

(II) OSMA

AIM HIGH



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Substance Abuse Education: An Essential Supplement to Medical School's Curriculum

• Until recently, substance abuse education has been lacking in Ohio's medical schools. However, there are ways future physicians can learn more about the treatment of substance abusers. A medical student from Wright State University's Medical School provides examples.

In 1987, at the American Medical Association annual meeting in Chicago, a major step was taken by the AMA

concerning the field of drug dependency. The AMA finally endorsed the fact that drug dependencies, including alcoholism, were diseases and their

treatment was a legitimate as well as necessary part of medical practice. Prior to 1987, alcoholism was considered to be a sign of weakness in an individual. This shift in medical ideology requires the medical curriculum to incorporate education on assessment, diagnosis and treatment of alcohol and drug dependencies.

Even though the shift is fairly recent, it is essential for medical students to understand that drug and alcohol dependency is a disease process, not unlike diabetes or hypertension. Students need positive mentors who demonstrate how to be effective clinicians with often difficult individuals who are afflicted with the disease of alcoholism. According to Wright State University School of Medicine instructor Margaret Bean-Bayog, MD, medical students' attitudes toward alcoholic people become steadily more negative over the course of their four years in medical school, due to the absence of positive training in this area.

However, the Weekend Intervention Program (WIP) offered in Dayton is an example of how substance abuse education can be effectively implemented into the medical curriculum. The WIP is an assessment program for individuals who are referred by the courts for driving under the

By Jane L. Uva



Medical Student Page



influence. Since originating in 1978, more than 23,000 clients have participated in the weekend. The weekend consists of educational lectures, films, AA meetings, and intense small group and individual sessions. One of the main goals of the weekend is to identify individuals with drug or alcohol problems and channel them into a treatment program. The medical students at WSU are required to observe one weekend within the course of their first or second year.

Harvey Siegal, director of the WIP, has written that the program was developed as a method to teach medical students several important facets of substance abuse — one, to identify alcohol and drug-related problems; two, to understand the phenomenology and dynamics of abusing patients; and three, to become aware of different treatment models for substance abuse. Finally, students

are asked to examine their own drinking and drug use. Findings indicate that the WIP is a successful vehicle for medical education in drug abuse and that the educational benefits are retained over time.

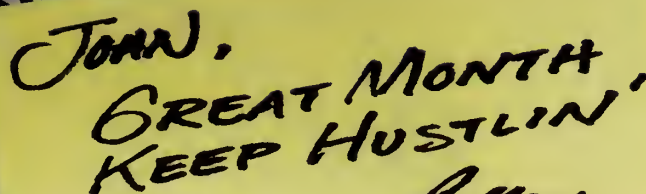
Another example of effective implementation of substance abuse education into the medical school curriculum is the JM and Scaife Family Foundation Scholarships for medical students concerning alcohol and drug abuse training. According to Phyllis Cole, the WIP program manager as well as the project coordinator of the scholarship program at Wright State University, the purpose of these scholarships is “to provide medical students with supplemental education in the area of substance abuse.” Currently, there are 16 scholarships available throughout the country.

Today, 10 million people have the disease of alcoholism. This

number does not reflect the enormous number of people who abuse alcohol and drugs. As physicians, today's medical students will face patients with blatant physical problems, based on the underlying abuse or addiction of substances. Unless medical students learn how to identify, diagnose, treat and refer such problems, many of these patients will continue to be treated only for the overt symptoms versus the original, underlying problem.

Consequently, medical students need positive mentors to show them how to deal effectively with the often difficult patient who does not feel drugs has adversely affected his/her life. The WIP and the JM and Scaife Family Foundation scholarships are two examples of how medical students can become better trained in substance abuse in order to be competent, yet empathetic physicians. **OSMA**

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Dr. Herbert Morris Platter— The Last Statesman

He was small of girth and stature but of grit and assertiveness he had plenty. His courage was interwoven with his drive to “do what is right at any cost.”

By Hart Page

CAE
Executive Director
Emeritus OSMA
and Historian



Such is the stuff of which “men of principle” are made, and from these emerge the statesmen.

Herbert Morris Platter, MD, was Ohio’s medical statesman. He was the state’s medical examination, licensure and

regulatory authority for half a century. His signature endorsed the medical certificates of Ohio’s medical doctors for 49 years.

When I first met Herbert Morris Platter, MD in 1946, he was already 77 years of age. Due to his continued competence in the performance of his duties the Ohio authorities continued to waive the age requirements and he was reappointed to his position as Secretary of the Ohio State

Medical Board through his 96th year.

When I joined the staff of the Ohio State Medical Association at the close of World War II, Charles S. Nelson, the executive secretary, assigned me to cover the Ohio State Medical Board and to spend at least two hours a week with Dr. Platter. I did, and for the next 20 years I listened, learned and enjoyed his friendship.

He was born in 1869, four years after the assassination of President Lincoln, to Mr. and Mrs. John C. Platter, a farm family of Lockbourne, Ohio, just south of Columbus.

He trained under Dr. Starling Loving. He told of accompanying Dr. Loving on house calls in the latter’s buggy and how the children loved his preceptor. One little patient proclaimed: “Dr. Loving I’m loving you most of all!” He had great respect and admiration for Dr. Loving and usually referred to him as “Ohio’s Osler.”

When, in 1899, the American Medical Association held its first and only meeting in Columbus, Dr. Loving was chair of the program committee.

He named Dr. Platter as secretary of the committee and assigned to him the bulk of the work. With a master stroke of innovation Dr. Platter arranged for

Medical History

an exhibit of 700 specimens of fresh pathology in a storeroom located near the present site of the Ohio Theater in Columbus.

The exhibit was an immediate success and out of it was born the Scientific Exhibit Program of the American Medical Association, which flourished and endured until modern times.

Sixty-five years later, just after Dr. Platter's 95th birthday, he was honored by the American Medical Association's House of Delegates for "his pioneering theories and spirit in promoting the first scientific exhibit. . . ." In his acceptance address to the House, the doctor dwelt not on the past, but on the future responsibilities of doctors of medicine and their organization.

It was in the hospitality room of the Ohio Delegation in the San Francisco hotel convention headquarters for that 1964 meeting, that Dr. Irvine Page of Cleveland asked Dr. Platter to explain his good health at his advanced age. The latter took a long pull on his "Dutch Masters" cigar, sipped a bit of his favorite drink, "bourbon and branch water," then framed his reply: "I practice all the vices . . . in moderation."

Dr. Platter attended Ohio Wesleyan University and received his medical degree from Starling Medical College in 1892. In 1893 he became the second house doctor at what is now St. Francis Hospital.

When the Ohio Legislature established the State Medical Board in 1896 Columbus physicians encouraged Dr. Platter to apply for the staff position of executive secretary. Apparently the competition was keen, and after a number of "ballots" he lost, but

When asked to explain his good health at his advanced age, Dr. Platter took a long pull on his Dutch Masters cigar, sipped a bit of his favorite drink, bourbon and branch water, then framed his reply: "I practice all the vices . . . in moderation."

he did accept the position of assistant secretary. His duties were to travel the state and inform doctors that it was now necessary to register with the State Medical Board, as well as with the local probate court, a prior requirement.

After a year of this he resigned to return to private practice and work with the Columbus Health Department.

Newspaper accounts indicate that his first office was at Town and Third streets. According to Mr. William F. Williard of Columbus his father, Dr. George W. Williard and Dr. Platter shared an office for several years at the turn of the century. It was a small building on North Fourth Street near the southeast corner of Gay and Fourth Streets.

According to Willard, this office was destroyed by a gas explosion, and Dr. Platter moved his location permanently to East State Street.

Dr. Platter served as city health inspector according to Willard, and was in charge of a small, dismal building on the west side, which was used for the quarantine of small pox victims.

The Willards resided at 215 North Fifth Street, and the Platters were next door. The two couples played bridge each week. They were life-long friends.

In 1902 Columbus was hit by a smallpox epidemic. Dr. Platter battled with anti-vaccinationists, including a local newspaper editor. According to newspaper accounts, when people began to die the anti-vaccination campaign evaporated.

Dr. Platter sought and found the source of the epidemic, a "floater" from Pittsburgh who died in a mission. He traced 27 cases to the attendance at the funeral of a friend of the man who carried the disease.

According to the news reports Dr. Platter became "one of the greatest living experts of smallpox" and he was later called upon to examine suspected cases in areas where the disease had not been seen by the profession.

A typhoid fever epidemic visited Ohio in 1903-04 and Dr. Platter was in the front ranks fighting the disease. He served the Columbus Board of Health from 1899 to 1908 in charge of work in contagious diseases.

Dr. Platter did more investigations of epidemics as epidemiologist for the State Health Department from 1908 to 1911. In 1911 he traveled to Berlin and Vienna for postgraduate study of skin diseases.

He opened his practice of

Medical History

Each year at the annual convention of the Ohio State Medical Association, Dr. Platter would “hold court.” He would chose a comfortable chair just outside the meeting room and would seldom leave the area. Medical leaders would pay their respects, seek his advice and hope for his approval.

dermatology in Columbus in 1912 and continued his private practice until 1954 when he closed his office in order to give full time to the Medical Board of which he had served as executive secretary since 1917.

From 1912 to 1917 he was chief of the Division of School Health for the Columbus Board of Education and helped to write the first Columbus public school health code.

In 1917 Dr. Platter had assumed the position of executive secretary of the State Medical Board and held this position until January 1966.

The licensing and regulation of a profession is never an easy task, and throughout his years with the Medical Board Dr. Platter worked closely with the professional associations and obtained their cooperation. During the years he served in numerous positions with the Columbus Academy of Medicine and the Ohio State Medical Association. The entire meeting of the Ohio State Medical Association in May, 1966 was dedicated to honoring him.

Each year at the annual convention of the Ohio State Medical Association, Dr. Platter would “hold court.” He would chose a comfortable chair just outside the meeting room and would seldom leave the area. Medical leaders, Ohio and national, would pay their respects, seek his advice and hope for his approval.

Dr. Platter was a friend and adviser to the members of the Ohio State Medical Association staff. During the years before World War II, when the pace of medical organization was not so rigorous, Dr. Platter, usually accompanied by Dean J. H. J.

Upham of the OSU College of Medicine would drop in at the OSMA offices at about 4 p.m. each day. The secretaries would leave, the doors would close and the good doctors would join “Chuck” Nelson and George H. “Scottie” Saville in a rousing game of poker until dinnertime.

Dr. Platter loved the game of poker, and his ready wit and long list of humorous stories added to his “popularity with the troops.”

There were many legislative battles with untrained healers who wanted an easy ticket to the practice of medicine, and Dr. Platter’s spotless record of public service and his fine personal life made him a man to be feared and respected.

He could be as firm as a rock if need be. He twice told a very popular governor: “Governor, I refuse to do it!” when commanded by the chief of state to issue certificates to the governor’s friends whose qualifications did not measure up to the Board’s requirements.

A rejected candidate for licensing physically attacked him on the street near the Board office, but this action further steeled the secretary’s determination to do his duty.

Dr. Platter was also an expert in medical-legal matters and lectured on medical law at the Ohio State University from 1928 to 1940. He more than once confided “If I hadn’t gone into medicine, I would have studied law.”

In fact, Dr. Platter was so well-versed in the laws and in the regulations with regard to the licensing and the practice of medicine, and so assertive in the interpretation and application of these provisions, that few lawyers had the temerity to challenge the

Medical History

Perhaps Dr. Platter's greatest impact on the national scene came through his active role in the Federation of State Medical Boards of the United States. He was known as the "Grand Old Man" of the federation.

Medical Board in the courts. This made it possible for the board to function in an orderly fashion.

The Medical Board under the Platter administration functioned efficiently and well with a small but loyal and hard-working staff of a half dozen persons, including three or more secretaries and three or more investigators.

The chief investigator, Frank A. Dorsey, served the Board for 44 years of the Platter administration, and Evelyn M. Hall was Dr. Platter's secretary for 22.

Perhaps his greatest impact on the national scene came through his active role in the Federation of State Medical Boards of the United States.

He was known as the "Grand Old Man" of the federation, having served as its president, and the annual luncheon meeting of the federation is permanently named the "Herbert Morris Platter Luncheon." He also served for 12 years as a member of the National Board of Medical Examiners.

Dr. Platter enjoyed good health in all his years, and in fact, never experienced a headache. He found it difficult therefore, to understand that symptom when discussing it with his patients.

To my knowledge Dr. Platter was in excellent health until the day shortly before his retirement when he was crossing Broad Street from his residence, the Deshler Hotel, he walked into a car and sustained some bruises.

I visited him in the hospital, bringing his two favorites, a box of Dutch Masters and a bottle of bourbon. He sent the nurse for glasses and we did justice to the whiskey.

The traffic accident led to his family's insistence that he retire,

and he did so at age 96, in early 1966.

He then made his home at the Lutheran Retirement Center in Columbus. I visited him a number of times and found him as perceptive and incisive as ever, giving me advice that was timely and well-founded.

Writing about the end is like saying "Goodbye" again. He formed a friendship with a business executive, a patient at the center, who enjoyed conversing and playing poker with the good doctor. He would stop by and walk with Dr. Platter to meals as well. As fate would have it, this fine gentleman decided to marry one of the woman residents and this meant a move to the married couples quarters.

The Grand Old Man was lonely, lost his appetite for food and for living. He became a victim of pneumonia and died November 4, 1966, at age 97, not quite a year after his retirement.

Dr. Platter was a widower for many years. His son, Harold O. "Bud" Platter was a successful and well-known insurance executive in the Columbus area for many years. His daughter, Mary (Mrs. Ralph) Lonius, lived in Birmingham, Michigan. OSMA

Obituaries

GEORGE W. BALLOU, MD, Cincinnati; University of Louisville School of Medicine, Louisville, KY, 1947; age 68; died November 30, 1990; member OSMa and AMA.

CHARLES E. CASSADAY, MD, Mt. Vernon; University of Cincinnati College of Medicine, 1941; age 77; died November 13, 1990; member OSMa and AMA.

ROBERT C. FOX, MD, Fremont; Ohio State University College of Medicine, 1938; age 77; died November 4, 1990; member OSMa and AMA.

LUDWIG GERE, MD, Columbus; Orvosi Fakultás Tudományegyetem, Budapest, Hungary, 1934; age 82; died November 26, 1990; member OSMa and AMA.

OSCAR F. GUTIERREZ, MD, Anniston, AL; Facultad de Medicina de la Universidad de LaHabana, LaHabana, Cuba, 1947; age 69; died November 11, 1990; member OSMa and AMA.

EDWARD J. HERSHBERGER, MD, Kettering; University of Cincinnati College of Medicine, 1936; age 82; died November 13, 1990; member OSMa and AMA.

CHARLES JOHNSTON, MD, Port Richey, FL; University of Toronto Faculty of Medicine, Toronto, Ont. Canada; age 86; died July 13, 1990; member OSMa and AMA.

THOMAS A. KRAUS, MD, Fairview Park; Georgetown University School of Medicine, Washington, D.C., 1955; age 61; died November 10, 1990; member OSMa and AMA.

CHARLES KRESGE, MD, Middletown; Indiana University School of Medicine, Indianapolis,

IN, 1971; age 45; died November 22, 1990; member OSMa.

JONAS MACIULIS, MD, Lakewood; Vytautas Didziojo University of Medicine Fakelteto Kaunas Lithuania, 1941; age 75; died October 15, 1990; member OSMa and AMA.

JOHN P. MINTON, MD, Columbus; Ohio State University College of Medicine, 1960; age 56; died December 1, 1990; member OSMa and AMA.

MABEL L. PEARCE, MD, Cleveland; Case Western Reserve University School of Medicine, 1930; age 87; died October 30, 1990; member OSMa and AMA.

ARTHUR L. SCHERBEL, MD, Scottsdale, AZ; University of Wisconsin Medical School, Madison, WI, 1944; age 73; died October 24, 1990; member OSMa and AMA.

MAURICE SCHNITKER, MD, Todedo; University of Michigan Medical School, Ann Arbor, MI, 1934; age 85; died November 8, 1990; member OSMa and AMA.

ALBERT C. SUNSERI, MD, Steubenville; University of Pittsburgh School of Medicine, Pittsburgh, PA, 1933; age 82; died November 23, 1990; member OSMa and AMA.

Attention Residents and Medical Students

Once again, *OHIO Medicine* is sponsoring a medical writing contest for medical students and residents located in the state.

A plaque and a \$250 prize will be awarded to both the resident and medical student who submits the most outstanding scientific paper, as judged by a distinguished panel of medical experts.

Last year, Daniel C. Morris, a medical student at the University of Cincinnati, won the medical student award for his paper, "Composition and Function of Pulmonary Surfactant and Its Implication in Respiratory Distress Syndrome of the Neonate." Louis A. Cannon, MD, won the resident award for his paper, "The Incidence of

Bacteremia Associated With Emergent Intubation: Relevance to Prophylaxis Against Bacterial Endocarditis."

Both entries were published in *OHIO Medicine* last year, and winners of this year's competition can also expect to see their works published.

All entries should be no more than 10 typed, double-spaced pages in length, and must be submitted by no later than March 1.

Winners will be announced at the 1991 OSMa Annual Meeting in Columbus.

Send entries to: *OHIO Medicine*, "Medical Writing Contest," 1500 Lake Shore Drive, Columbus, Ohio 43204-3824. OSMa

Lady Godiva Syndrome

By Alvin Rodin, MD and Jack Key

**Lady Godiva,
the wife of Leofric,
the Earl of Mercia,
made a horseback
ride through the
marketplace in
Coventry, England,
in order to get
her husband to
reduce his
excessive taxes,
which he then
did.**

Lady Godiva has been used as an eponym for genital exhibitionism.¹ One motivation is an abnormal compulsion, usually in a male, to expose his genitals to the opposite sex.² Its development is related to a fear of castration and the need to reassure oneself that one is able to perform sexually.

Lady Godiva, the wife of Leofric, the earl of Mercia, made a horseback ride through the marketplace in Coventry, England, in order to get her husband to reduce his excessive taxes, which he then did.³ She was completely nude except for her long hair, which covered her body down to her legs. Although Lady Godiva may have been a historic individual in 10th century England, her ride is considered to be legendary. St. Agnes is another woman whose hair covered her nakedness, in this instance after she was stripped naked when persecuted as a Christian (see Agnus Castus).⁴

Lady Godiva is not a good example of exhibitionism because her primary motivation was not sexual, because she was as covered with hair as she would have been by clothes, and because the condition occurs predominantly in males. Jean Jacques Rousseau, in his *Confessions*,⁵ described an episode of his own exhibitionism

before several girls who came to a well. It was a time in his youth when "My heated blood incessantly filled my brain with girls and women." He was caught by a man with a sword, but released after pleading that he was a stranger "whose brain was affected." Another example of exhibitionism occurs in Hans Christian Andersen's "The Emperor's New Clothes,"⁶ but this was involuntary because the emperor believed he was the only one who couldn't see his supposed clothing. **OSMA**

1. Vaisrub, p.22.
2. Freedman, pp. 1,542-1,543.
3. Encyclopedia Britannica, IV:595-596.
4. Williams, p.39.
5. Rousseau, J. J.: *The Confessions of Jean Jacques Rousseau*: New York, Modern Library, n.d., pp. 90-92.
6. Andersen, H. C.: "The Emperor's New Clothes": in *Hans Christian Andersen, The Complete Fairy Tales and Stories*, E. C. Haugaard translator, Garden City, New York, Doubleday, 1974, pp. 77-81.
7. Brewer, 2:100.

Reprinted with permission from *Medicine, Literature and Eponyms: An Encyclopedia of Medical Eponyms Derived From Literary Characters* by A. E. Rodin, MD and J. D. Key; Robert E. Krieger Publishing Co.; Malabar, Florida, 1989.

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Am Fam Phys 1987;36:133-140

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Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
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- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritic/arthritis, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, serum-sickness-like reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy, occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.

- Stevens-Johnson syndrome, toxic epidermal necrolysis,

and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.

- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypotonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

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- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
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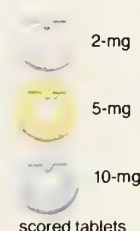
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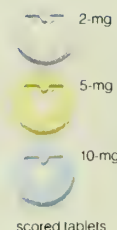
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Edouard Manet's self portrait

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COVER STORY

The avant-gardé artist Edouard Manet broke with traditional French painting in his technique and in his subject matter. It has frequently been said that the greatest service Manet rendered to art was to lighten the painter's palette, to make luminous and dazzling what his predecessors had lost in darkness and useless halftones.



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Despite the War . . . Our Problems Stay

By John A.
Devany, MD

President of
the OSMA



It is now January 19. Operation Desert Storm is less than 72 hours old. We are being told it is going well, but now the surge of exhilaration is waning and the realization that very hard times lie ahead, with stern tests for this

nation's medical resources, both at the front and at home, are apparent.

It is a bizarre feeling to be listening to our reporters speaking from a city we are bombing. As an old flight

surgeon for a fighter squadron, you gradually start to feel you should be there, and then you read that John P. King, MD (a 63-year-old OSMA member) from Reynoldsburg had volunteered for service in Saudi Arabia with the 160th Air Refueling Group (OANG). May God go with him and all of our forces.

It is only a matter of time 'til we will be seeing a rash of TV mysteries with some Arab as the arch villain. I feel like I should call all my Arabic friends (and they are many) and tell them they

are no more responsible for this than I am.

Wars have a way of putting problems in a different perspective, but they don't make them go away. We all know that Americans can count on paying the expenses of this war — for years. Everything may well be on hold, but the demographics go on. What will happen to health care? More of the same, only worse. The future will not be kind to the status quo. Much of the future is not positive. The administration will talk a good game but won't spend any money. Organizational efforts may well influence, sometimes even diminish the effects—but they cannot reverse the same.

The darkening economic picture has already caused the Bush Administration to ask lawmakers to cut more than \$2.5 billion from the Medicare budget in 1990 alone, and a total of \$20 billion from 1992 to 1996. About \$2.7 billion would be through physician fee reduction.

The OSMA did receive good news regarding the Health Care Financing Administration's refusal to release millions of dollars in Medicare contingency funds. We had reported to you earlier that the Federal Office of Management and Budget was refusing to allow \$101.3 million of Medicare contingency funds to be released to HCFA. Because of this refusal

Presidential Perspectives

HCFA had said Medicare carriers must build a backlog of claims to 60 days. Remember that the Nationwide Medicare claims backlog in 1989 was 35 days and caused many OSMA physicians severe cash flow problems. The 60-day backlog would cost the government \$81 million dollars in interest (all out of the same kitty). The OSMA had asked members to write OMB to express their concern regarding this situation. Thanks to your swift response and intensive lobbying by the AMA, OMB has agreed to release a portion of the money, enough to avoid the two-month delay.

It is amazing to me that the figures released by HCFA regarding the total dollars spent on health care last year shows that physicians were paid 19%. That figure has stayed constant since figures were first kept in 1951. You know that I quarrel seriously with what is classified as to health-care cost, but using their figures, 39% went to hospitals, 8% to nursing homes, 22% on dental and other professional services, home health care, drugs and vision products. The remaining 12% paid for administration, research and construction.

Of the total dollars spent on health care, 33% was paid by private insurance, 21% by self-paying consumers, 17% by Medicare and 10% by Medicaid.

You don't need to be told that utilization review screens and practices vary radically across the country. There is virtually no regulation, federal or state. ERISA preempts state regulation of self-insured plans. UR companies are free to make arbitrary judgments, knowing there is no recourse. The AMA has asked the Department of Labor to establish federal minimum standards or to allow

state regulation of private UR companies. The request stressed that consistent and appropriate regulation of those companies is essential so UR is not used as a guise for arbitrary cost savings and patients are not denied needed care.

The AMA has also asked HCFA to accord physicians full due process rights during the sanction process. At a minimum, PROs should disclose the reviewer's identity and credentials, as well as all of the facts prior to issuing a sanction recommendation. (These seem like particularly bizarre happenings at the same time as Desert Storm.)

At the State Health Legislation Meeting the 1991 State Legislative Survey was reported showing:

1.) Access to health care for uninsured is the biggest problem in each state. Many, if not most, have written off Washington. Private sector cannot solve the problem alone.

2.) Mandatory assignment. Here it comes again.

3.) Allied and paraprofessional health incursions.

4.) Nursing issues. Nurses say they are the only general practitioners left.

5.) Medical discipline problems.

6.) AIDS.

7.) Liability worries may possibly be down.

8.) Animal rights pressure. Animal activists are winning because of our failure to educate people. Rats do not have the same rights as babies. Keeping research alive keeps hope alive.

The similarity of issues across state lines and the diversity of interested groups reinforces, again, the need for coalition building.

In the final days of the 1990 legislative session, the Ohio Senate Financial Institution and Insurance

Committee passed a bill requiring health insurance policies and HMO contracts to provide for mammography screening (HB 642). The bill was amended at the behest of BC/BS Cleveland to prohibit balance billing, and the benefit was capped at \$89. This legislation ultimately failed. This action really fits an aggressive drive by the insurance industry to cap physician payments. Pennsylvania and New Jersey have enacted measures placing caps on services pursuant to motor vehicle injuries.

Amid all of these problems, it was amusing to read in the *Dayton Daily News* about the increasing list of situations for which patients must have doctors' excuses in order to gain the system, and, of course, we are in the middle. One doctor was asked to state that the patient's arthritis kept him from filing income tax for two years. I'll bet it didn't work.

Let me take this opportunity to congratulate Ed Kilroy on his appointment as Ohio Director of Health. Ed is a man who likes a challenge — a hard worker, truly dedicated to good patient care. He has our good wishes.

Shalom. OSMA

A Tribute To Physicians

By Sue Massie

**OSMA Auxiliary
President**



The image of the physician has undergone a drastic and devastating change in the last two decades, but those of us in a position to see the day-to-day commitment of physicians know that the "dear and glorious"

physician is still a reality today.

Though the time commitment to hitch up the horse and buggy is no longer required, the demands upon the time of physicians are, if possible,

increasing. We do not see Dr. John Smith sitting in the corner coffee shop visiting with all the townspeople, because he must be at the hospital at 6:00 a.m. to make grand rounds before he starts surgery at 7:00 a.m. He attends a continuing education program at lunchtime and hurries to arrive at the office by 12:30 p.m.

A pharmaceutical salesman visits at the office to inform the physician of new, improved medications. Then, he must see the patients scheduled and work in those emergency calls or be called

insensitive. A call to the hospital because a patient is ready to deliver will delay or eliminate dinner, and he is expected to be at the local civic club to present a program on his specialty by 7:00 p.m. Then, a friend of the family would like him to stop by or meet him at the office because the cold he has had for three days suddenly is a critical issue. In addition, the physician must view some audiovisual tapes and do some reading in the medical journals before bedtime so that he can be up to date on current medical information.

In order to have staff privileges, the physician must attend staff meetings and serve on a variety of committees to ensure proper infectious disease controls, surgery procedures, emergency room guidelines, etc. In addition, he may serve on the hospital Board of Trustees to provide medical input so that the hospital proceeds in a proper manner medically speaking.

Civic and community organizations request the physician's personal involvement in their local drives or programs; the local science fair needs qualified judges for the health-related projects; the football, basketball, baseball and other sports teams need physicals; the local health department needs a medical consultant; and the local clinics

Continued on page 153

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Second Opinion

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Self-Help for Troubled Teens: Delancey Street in the Desert

The health and welfare of America's children is a matter of urgent concern. Poverty, with its handmaidens of poor education, out-of-wedlock pregnancies and substance abuse, is a great adversity. The "war on

poverty" of the 1970s was followed by many other programs, yet the cycle of youthful destruction has not been broken. More and more people are slipping below the poverty line. School dropouts are

increasing. More young girls are becoming pregnant. We are at risk of losing an entire generation.

Since many current programs are not succeeding, alternatives should be examined. We would like to relate our understanding of one such program, Delancey Street, a self-help, residential program that serves hard-core adolescents. Here,

children who are abused, dependent, and living antisocial, self-destructive lifestyles are treated.

On a trip to New Mexico, we visited the Delancey Street Foundation. It includes five facilities with 700 residents. One refreshing bit of news is that this foundation receives no government funds and asks for none. Nor are third-party payments taken.

The emphasis is on self-help. All residents must work. New residents are called "immigrants," after the famous Delancey Street of New York's Lower East Side, the first U.S. residence for many immigrants. All newcomers work for at least six months within the confines of the compound. Those on the road to rehabilitation work in the community or in the network of businesses owned by the foundation, such as catering services, selling supplies to college stores and landscaping. All income is pooled. By chance or design it is an American kibbutz.

All residents who enter must accept personal responsibility for their antisocial behavior. They must refer themselves for help. Most have long records of substance abuse, prostitution and other criminal behavior. School learning is first on the program. Residents work toward a degree in general education. Next is vocational training in the myriad



**By Ralph I. Fried, MD,
and
Judy Sherman, BA, MS**

Second Opinion

of small businesses owned by the foundation. The foundation says that "residents who have been long-time unemployed have worked and managed these businesses so successfully that these enterprises are a primary source of funds."

Group therapy is an important means of restoring a sense of self-worth to the long-term delinquents. Along with training to instill self-confidence and self-discipline, residents are taught to develop a work ethic and basic work skills.

Delancey Street Foundation sums up its philosophy as follows: "The residents gain the vocational, personal, interpersonal and social skills necessary to make restitution to the society from which they have taken illegally, consistently and often brutally for most of

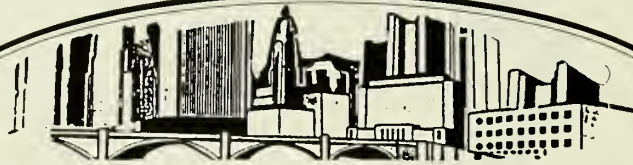
their lives. In return, Delancey Street maintains and demands from society access to legitimate opportunities from which the majority of residents have been blocked for most of their lives."

By living together and pooling their resources, residents gain enough strength and credibility that their demands for access to society must be taken seriously. The process of gaining the skills, abilities, and self-concept necessary to make and receive social restitution requires a minimum of two years. The average stay prior to graduation from Delancey Street is three and one-half years. Delancey Street acknowledges a 35% attrition and claims great success with the remaining 65%. Residents become useful citizens, well integrated into the community.

Some have reached managerial levels in free enterprise. Some have achieved professional status.

The loose structure of the Delancey Street Foundation is startling at first. In stark contrast to most social agencies, there are no paid professional personnel, no social workers, no psychologists or psychiatrists, or even accountants to supervise the financial structure. There is no board of trustees. The most refreshing and exciting aspects of the Delancey Street Foundation are the concepts of self-help and individual responsibility.

Paternalism, the backbone of current government and private agencies, is failing to reduce the incidence of many problems. We must search for alternatives. Delancey Street is one. OSMA



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Hospitals Are the Target, Not the Cause

By James R. Castle,

**President, Ohio
Hospital Association**



It is not surprising to learn that most Ohioans don't know what is happening to hospitals across Ohio today. One's first

thoughts about health care usually turn to the needs of a loved one and their physician — which is probably how it ought to be.

Unfortunately, this lack of awareness, even by those who work in health care, hurts our health-care system.

State and federal policymakers often make their decisions on their perceptions, and hospitals — it seems — are easy targets in times of crisis. When the need arises for health-care reform or when state and federal budgets need to be tightened, hospitals become the first focus of attention.

One area of particular concern now is Ohio's Medicaid budget. The Ohio General Assembly is currently debating the funding of

that program for the next two fiscal years, and misperceptions abound. In the final three weeks of the Celeste Administration, the Department of Human Services proposed a cost-containment scheme for the state's Medicaid budget. In that proposal, hospitals were asked to assume additional cuts of more than \$50 million. It was somewhat of a surprise, considering the department — only a few weeks before — publicly stated that hospitals were not the primary cause of spiraling increases in the Medicaid budget.

New information reveals that hospitals have substantially curbed their Medicaid budget needs, while serving more poor Ohioans than ever before. In 1983 a new payment system for inpatient hospital care was developed — a Medicaid prospective payment system based on DRGs, diagnosis-related groups. The state developed this new system to help restrain spending, and hospitals have been a partner in this effort.

In the five years before the DRG system was developed, from 1978 to 1982, annual Medicaid increases for hospitals averaged 20.3%. From 1983 through 1990, the average annual Medicaid increase for hospitals dropped to 7.9%.

Guest Editorial

This is still higher than hospitals would like to see it; however, it must be noted that Medicaid increases to all other providers during the past eight years was 14.2%, which is almost twice the hospital rate.

Other facts also clearly show how hospitals continue to work to keep their costs down. In 1983 the portion of the State's General Revenue Fund devoted to hospitals, mostly through Medicaid, was 4%. Eight years later, the hospital portion is virtually unchanged at 4.1%.

During the same time period, 1983 to 1990, the portion of the state's Medicaid budget devoted to hospitals dropped substantially, from 43.7% to 32.3%. That's a reduction of 11.4% over the past eight years.

While the proportion of Medicaid dollars to hospitals has decreased, the demand for Medicaid services has exploded. According to the Health Care Financing Administration, the number of Medicaid recipients in Ohio grew about 224,000 from 1983 to 1989 — from nearly 911,000 persons to more than 1.1 million. This was a 20% increase. Much of this increase is a direct result of federal mandates rather than a result of recessionary Ohio economy.

This dramatic increase in recipients is compounded by rising societal problems that always seem to end up on the hospital door step for a remedy . . . problems like drug abuse, AIDS, street violence and teen pregnancies continue to stress already burdened hospital resources.

In the past few years, financial margins in Ohio hospitals have grown razor thin. In fact, nearly half of the hospitals in this state are now losing money on operations. These are difficult times for most hospitals and, more importantly, the patients they

- **In 1989, Ohio hospitals lost \$173 million providing care to Medicare patients;**
- **In 1988, they lost \$48 million caring for Medicaid beneficiaries.**
- **These same hospitals provided \$487.7 million in charity and bad debt care during 1989. This problem is being driven by the increasing numbers of uninsured in Ohio, who now number about 1.3 million.**

serve. Consider the following:

- Hospitals are now reducing or eliminating services to their communities as they struggle to make ends meet.
- Two hospitals in Ohio closed last year: Wellington Community Hospital in southern Lorain County and St. John in Cleveland.
- Nearly 2,000 hospital employees have lost their jobs in the past 12 months.
- Many hospitals in Ohio that

aren't making ends meet today may not stay open another year.

As these trends continue, more and more patients will encounter access problems when they have to seek care further from home — problems such as a lack of regular transportation or the need for child care.

What's causing this distress?

- In 1989, the year in which the latest data is available, Ohio hospitals lost \$173 million providing care to Medicare patients;
- In 1988 they lost \$48 million caring for Medicaid beneficiaries. Both of these figures come from studies conducted by the national accounting firm of Ernst & Young.
- These same hospitals provided \$487.7 million in charity and bad debt care during 1989. This problem is being driven by the increasing numbers of uninsured in Ohio, who now number about 1.3 million, according to the Ohio Department of Human Services.

To put these losses in more understandable terms, if there had been no losses in these programs, the average hospital bill could have been reduced by at least \$500. According to new preliminary data, these losses continued to increase last year and this year, and will likely continue for the foreseeable future.

This is the kind of information that must be made better known if government policies are to reflect what is really happening in the health-care field. By working together, hospital executives, physicians and other health-care providers can begin to dispel the misperceptions and focus attention on meaningful solutions. **OSMA**

James R. Castle is president of the Ohio Hospital Association.

Is It Too Late for Me To Be a Political Activist?

Your Letters to Legislators Do Make A Difference

By Mark A.
Bechtel, MD



and bill patients for medical services will be greatly altered in the future. On a state and national level are calls for national health insurance or universal health insurance modeled after the Canadian health-care system. Fortunately, attempts to take away the control from physicians for prescribing medications to Medicaid patients through therapeutic substitution by pharmacists was defeated. It is very obvious that the very heart of private medical care and its many virtues are being threatened.

Many health-care laws and regulations are being drafted by

The impact of government on the practice of medicine is becoming increasingly clear. With recent federal legislation, the way we perform our office laboratory evaluations

government personnel and legislators who lack insight into many critical health-care issues. Although their intentions and goals are admirable at times, they often lack insight into the impact of their proposals on basic health-care delivery and quality care concerns. The political system is not entirely at fault for this situation. Physicians have failed to be sufficiently active in informing legislators about important health-care issues and concerns. They have not played an active role in supporting politicians who share favorable views and concerns about our medical care. Doctors always complain that they have very little free time and much more important responsibilities than being involved in political issues.

We must take an active role in the political process if we hope to make any impact on the future direction of medicine in our country. This can be accomplished by educating our state and national legislators about important medical issues. Letters to legislators can be very effective if written well, in a timely fashion and in adequate numbers. Letters should direct concerns about the

Continued on page 135

Cincinnati tackles prescription abuse

Cincinnati police are taking a hard-line stand on prescription drug abuse with a new pharmaceutical diversion unit, organized late last year as part of its vice-control section. Its staff consists of four officers and a sergeant.

"We're looking into everything that has anything to do with pharmaceuticals," Sgt. John Burke, the officer in charge of the unit, said in news reports. "We're looking for any kinds of abuse, including people who steal doctors' prescription pads and people who make their own fake prescription pads."

The unit is expected to help area physicians face a long-standing problem of dealing with people who claim to be patients and ask for prescription drugs.

Since the Regional Enforcement Narcotics Unit merged with the federal Drug Enforcement Agency in 1986, abuse of pharmaceuticals has been left unchecked, says Sgt. Burke.

Anyone who knows of any pharmaceutical abuse in the Cincinnati area may report it by calling (513) 352-1610.

Illegal steroid use latest battle in war on drugs

The war against drugs is nothing new, but here in Ohio the latest assault has been waged against a drug that has received little attention in the fight so far — anabolic steroids.

Yet, in Akron, a local athletic club recently opened this new front



in the war by holding a one-day seminar, "Athletic Success Without Steroids." Participating in the seminar were area sports medical physicians, exercise physiologists and former football players, all of whom explained to 110 young athletes, coaches and parents the potential risks related to improper steroid use. In addition, the audience learned how to recognize signs of steroid use, as well as alternative ways of building strength, including improved nutrition and exercise techniques.

Said one seminar speaker, "If they've (become) stronger with steroids, they can get stronger naturally. The genetic potential is there."

According to Ohio law, "A physician shall not utilize anabolic steroids, growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG) or

other hormones of enhancing athletic ability." (OAC 4731-11-05 (A). A violation of this provision is grounds for discipline by the State Medical Board.

Ohio may soon see "second wave" of AIDS

A "second wave" of the AIDS epidemic seems to be striking the U.S., and Ohio may start to see telltale signs of it soon.

Unlike the first wave of AIDS, which seemed to have its greatest effect on gay men, the new epidemic is composed of cases stemming from behaviors involving unprotected, heterosexual intercourse and intravenous drug use. Consequently, population groups previously untouched by the HIV virus are beginning to show an increasing number of victims.

Women, for example, now make up 6% of the more than 2,200 cases of AIDS reported around the state — reflecting a nationwide trend that shows more and more women are being struck with the HIV virus.

Another group showing up in this "second wave" of AIDS victims are people aged 50 and over — 17% of whom received infected blood through transfusions before routine screening began in 1985. The most recent data from the federal Centers for Disease Control shows 15,696 cases reported in this age group, approximately 10% of the entire AIDS population. Ohio, however, does not appear to be following the national trend. Only 202 Ohioans, 50 years and older, have been diagnosed with the HIV virus.

Finally, the increasing number of

Ohio Medi-Scene

intravenous drug users who are becoming infected with the HIV virus is creating a disproportionate spread of AIDS among black and Hispanic populations — not only nationally, but here in Ohio. As a result, Ohio Department of Health Director Ronald Fletcher, MD is calling for more culturally sensitive and specific prevention efforts. The ODH recently completed a videotape on women and AIDS, funded by the CDC through a grant to the American Association for World Health. The tape, which is being distributed nationally to African-American colleges, focuses on AIDS and women of color.

UC targets its stop-smoking class

The University of Cincinnati Medical Center has started a quit-smoking class, composed entirely of economically disadvantaged blacks.

Funded by a grant from the American Heart Association, the program is being offered through the center's Division of Nephrology and Hypertension and has been specifically developed for that population, which is at the highest risk for coronary heart and lung disease, and yet who have limited resources for enrolling in programs like this.

Participants attend a series of seven classes, paying \$5 as a form of commitment toward the course, which typically costs \$65. The American Lung Association donated books and kits from its "Freedom from Smoking" program to the special class.

The center's immediate goal is to enroll 200 people in its class over the next two years, then turn



the program over to the black community to operate. Its more long-term goal is to develop the program as a nationwide model for economically disadvantaged minorities.

PEP program receives support

The OSMA Physician Effectiveness Committee wishes to recognize the following organizations for providing major funding and support services for start-up of the full-time professional staff for the Physician Effectiveness Program.

Ohio Hospital Insurance Co. \$ 30,000

Ohio Medical Education & Research

Foundation	\$ 10,000
Ohio State Medical Association	\$ 50,000
Physicians Insurance Co. of Ohio	\$ 30,000
The PIE Mutual Insurance Co.	\$125,000
Academy of Medicine of Cincinnati	office space for southern Ohio staff
Academy of Medicine of Cleveland	professional office space for northern Ohio staff
Academy of Medicine of Columbus & Franklin County	professional office space for medical director and secretary

"To say these organizations are unsung heroes would be a vast understatement," says Edward T. Carden, MD, chair of the Physician Effectiveness Committee. "Their willingness to commit funding and services at this time will enable us to initiate statewide education, intervention services and liaison with the Ohio State Medical Board for the ultimate benefit of hundreds of physicians impaired by alcoholism, drug dependence, psychiatric disorders, and other problems including 'fallout' from malpractice suits."

Dr. Carden added that a strong effort is being made to seek permanent funding for the project through interest generated by the Joint Underwriting Association. OSMA and the malpractice insurance companies are already laying the groundwork for state legislation to earmark JUA funds.

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AIDS training urged for day-care staff

A recent study found that day-care centers are not well prepared to handle the influx of children who have AIDS.

Dolores Stegelin of the University of Cincinnati believes day-care administrators and teachers need to be trained to work with children who have AIDS. "More children are being born with AIDS, but there hasn't been much training done in the (day-care) field," she said.

Stegelin and co-researcher Penelope Wetterau, a former assistant professor of health and nutrition sciences at the university, are considering producing literature on the subject or helping draft health-care policy recommendations. Stegelin presented her case at the National Association for the Education of Young Children Conference in Washington, D.C., recently.

In 1989 the two women sent a survey to 187 day-care or child education centers in the region of Cincinnati and northern Kentucky. A total of 561 people responded — a 50% return rate.

One part of the study dealt with the person's knowledge of AIDS and the other part sought the person's views about working with children who have AIDS. Stegelin found little relationship between what a person knew about AIDS and what their fears were. In general, most felt a high level of anxiety about working with children with AIDS.

Many day-care directors questioned said they would welcome AIDS-training courses for their employees.

This is a problem that is not going away soon. According to the Centers for Disease Control, there have been 2,233 reported pediatric AIDS cases nationwide between



when the Centers for Disease Control began compiling such statistics in the early 1980s in October. That increased from 1,614 known cases in December 1989.

Laser blasts kidney stones

Urologists in the Dayton area recently observed a laser that could blast kidney stones without disturbing the normal surrounding tissue. The new technology may soon be available to patients locally, as well as other areas around the state.

A consortium of major Dayton hospitals have expressed strong interest in purchasing the laser lithotripter produced by the Candela Laser Corp.

Unlike most lasers, the lithotripter doesn't produce intense heat, explained demonstrator Malcolm Coptcoat, MD, of Kings College Hospital in London, England. It has a "photocoustic effect," a laser-induced shock wave which, because of its wavelength, doesn't harm normal tissue.

The device is so sensitive it was described as being able to take an

eggshell off an egg without breaking the membrane underneath.

The laser beam is delivered to the stone through a fiber three times the size of a human hair, which fits into a small scope. Coptcoat explained that the scope is then introduced into the body "through the normal channels."

This laser procedure involves less pain and recuperation than the present ultrasound treatments. This procedure can often be done on an outpatient basis.

Urologists believe the laser could benefit 200 to 300 Dayton area patients annually.

Cuyahoga County study shows high rates for breast cancer

Cancer Data System released a study that shows that women in Cuyahoga County are more likely to develop breast cancer than women nationally. The study shows that the annual incidence of breast cancer among black women in Cuyahoga County is 109 per 100,000 or 23% higher than the national average of 90. The rate for white women is 118 per 100,000 or 12% higher than the national average of 105.

The study compared Cuyahoga County's 1987 cancer data to national figures compiled by the National Cancer Institute. The next step is to analyze the Cuyahoga County data by census tract to see whether people in any particular area have a higher incidence of cancer. The process, to be completed this spring, could show whether people in any particular area have a higher incidence of cancer.

Ohio Medi-Scene

Cancer Data System, a non-profit corporation affiliated with the Greater Cleveland Hospital Association, hopes to get additional funding from the state and county to collect data for subsequent years, and to track survival rates.

Ohio rep fights elderly abuse

Rep. Mary Rose Oakar, D-20 of Cleveland, is sponsoring a proposed \$11 million Elder Abuse Prevention Act, which would create a National Center on Elder Abuse to disseminate information and fund programs to prevent, detect and treat abuse of the elderly. In 1988, one and a half million elderly Americans reported abuse, a 50% increase in reported incidents since 1980.

Rep. Oakar believes the increase in elderly abuse may be in part due to the increase in elderly Americans. The number of people age 100 or older has increased from 3,200 in 1968 to 45,000 in 1990.

Unfortunately, only one case of abuse in eight is reported because many victims fear reprisals or have an "instinctive love for their children" who abuse them, says Rep. Oakar.

Shirley Rhodes, a member of the Ohio Coalition for Adult Protective Services, said that between July 1989 and June 1990, 10,396 elderly Ohioans reported being abused, neglected or financially exploited. A total of 7,050 such reports were made in 1986. **OSMA**



Edward Kilroy, MD

New state health director

Edward Kilroy, MD, Cleveland, has been named Director of the Ohio Department of Health by Gov. George Voinovich. Peter Somani, MD, director of the division of Clinical Pharmacology at the Medical College of Ohio in Toledo, has been named assistant director of health. The job of the ODH director is to enforce state health laws and serve as the governor's key policy adviser on health matters. Dr. Kilroy is a former Fifth District Councilor of the OSMA.

Task force tackles learning disabilities

Children who have difficulty in school may be suffering from learning disabilities that often go undiagnosed, says Gerald Castor, an Akron audiologist who is part of a special OSMA Task Force on learning disabilities, and how they should be defined by the medical

community. The ad hoc task force grew out of a resolution presented to the 1989 House of Delegates by Richard Orlando, MD.

That resolution (Amended Resolution 38-89) called for a multidisciplinary task force to study the issues of learning disabilities and appropriate diagnostic procedures and treatments — with the ultimate goal of sharing that information with the public.

The task force is presently conducting a survey of a cross-section of Ohio's practicing family physicians, pediatricians, ophthalmologists, neurologists and psychiatrists to determine how they approach learning disabilities in their respective practices.

Once the study is complete, the task force hopes to publish the results and make recommendations for approval to the OSMA Council and pertinent specialty societies.

Members of the special OSMA task force are: Eric W. Lothes, MD, Dublin, Chair; Gerald Castor, Akron; Louis J.R. Goorey, MD, Columbus; Vicki Jahns, Cincinnati; Ellen King, RN, PhD, Columbus; Celia Neavel, MD, Cincinnati and Joseph Todd, Worthington. **OSMA**

OSMA loses two past presidents

The Ohio State Medical Association recently lost two past presidents within days of each other.

Frank H. Mayfield, MD, Cincinnati, was president of the OSMA from 1959-1960. An internationally recognized neurosurgeon, Dr. Mayfield



Frank Mayfield, MD

Ohio Medi-Scene

was the first recipient of the Harvey Cushing Medal, given by the American Association of Neurological Surgeons.

Edwin Artman, MD, was Dr. Mayfield's successor to the office of OSMA President (1960-1961). He was retired, and had been living in Sun City Center, FL.

Colleagues

Edmund W. Jones, MD, Cincinnati, has been elected to fill an unexpired term on the Governing Council of the AMA's Hospital Medical Staff Section.



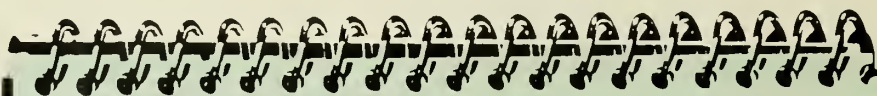
Edmund W. Jones, MD

Steven P. Combs, MD, is the new president of the Lake County Medical Society. **Patrick Convery, MD,** is the new president-elect, and **John Ouligian, MD,** has been elected Lake County's secretary-treasurer.



Steven P. Combs, MD

Arthur G. James, MD, Columbus — after whom the Ohio State University's cancer hospital and research institute is named — was recently awarded the American Cancer Society's Medal of Honor, the society's highest award. Dr. James was recognized for "outstanding leadership in the field of cancer control," and for his service as president of both the Society of Surgical Oncologists and the ACS.



Clinical Clips

44,000

Number of women who die from breast cancer each year

1 out of 5

Number of women over age 49 getting yearly mammograms

7,000 to 10,000

Number of infants who die from SIDS each year

166

Number of Ohio infant deaths attributed to SIDS

88.3%

Percentage of those deaths that underwent autopsies

11

Number of states that require autopsies in suspected SIDS cases

10,000

Number of young adults suffering strokes each year

16%

Percentage of increase in drug-related strokes from 1986 to 1988

10 hours

Number of hours doctors spend reading medical material weekly

\$500

The amount of money spent on materials to keep up to date

1 out of 5

Number of doctors in solo practice

36%

Percentage of physicians in group practices

32%

Percentage of doctors who expect practice to grow financially

20%

Percentage of doctors who see their income declining

39%

Percentage of doctors who see no change over the next five years

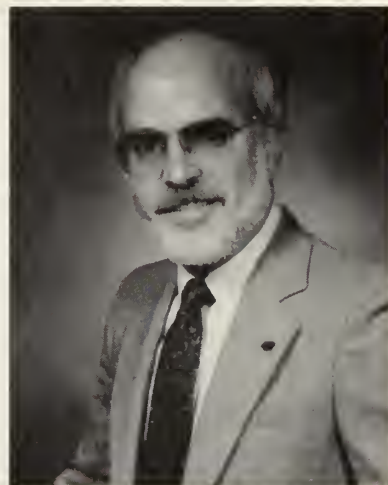
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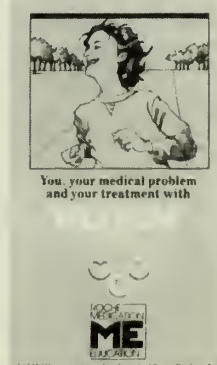
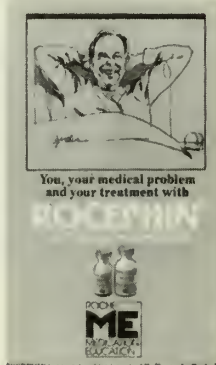
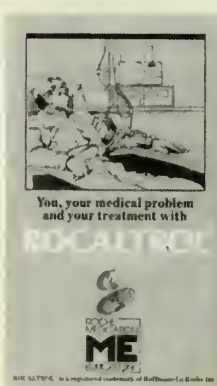
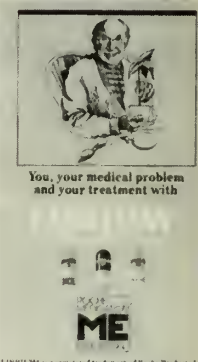
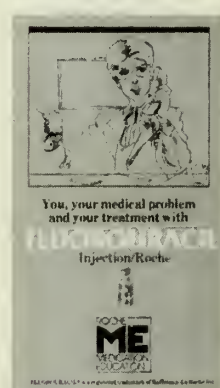
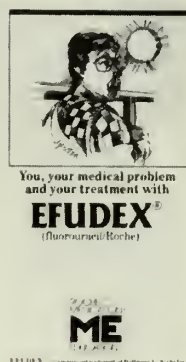
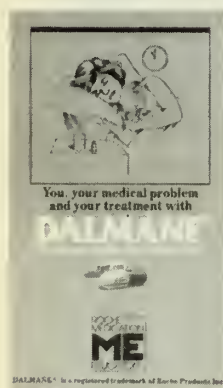
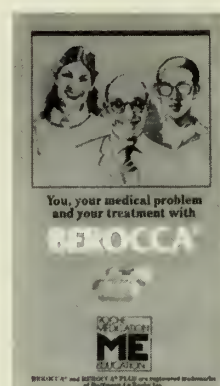
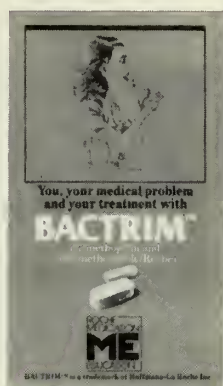
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OSMA Constitution and Bylaws

Editor's Note: The following proposed revision of the OSMA Constitution and Bylaws will be considered by the OSMA House of Delegates at the 1991 Annual Meeting. Pages 107 and 108 describe the recommended changes, and pages 109-131 are the revised editions of the documents.

Proposed Revision of OSMA Constitution and Bylaws

In June, 1990 the Council of the Ohio State Medical Association decided it was time to review the entire OSMA Constitution and Bylaws for the first time in 20 years. Council referred the initial review to the Committee on Judicial and Professional Relations. The Judicial and Professional Relations Committee and the Council considered a multitude of policy issues and debated several extensively. The resulting amendments proposed to the House by the Council do not significantly alter the OSMA's structure or policymaking process. Rather, the amendments will give the OSMA the flexibility to meet the challenges facing the OSMA membership and their patients.

This document is presented to the 1991 House of Delegates as an amendment to the present Constitution and Bylaws pursuant to Article XI, Section 1 of the OSMA Constitution and Chapter 15, Section 1 of the Bylaws.

The remainder of this article

discusses the changes recommended by the Council to the House of Delegates. Existing language to be deleted is written in regular type with hyphens ~~through the type (thirty-(30)-)~~. Proposed new language is CAPITALIZED.

Issues

I. The Council considered the disciplinary process of the OSMA in light of the enactment of the Health Care Quality Improvement Act of 1986. OSMA Counsel Bill Todd, J.D. and Terri Lynn Smiles, J.D., (outside Counsel to OSMA) reviewed the relevant sections of the Constitution and Bylaws. The Council recommends these modifications so that our Bylaws will comply with the mandates of the federal statute. Compliance with the statute will give the OSMA increased protection from antitrust litigation. The new language also recognizes the necessity of reporting final OSMA disciplinary actions to the National Practitioner Data Bank. The

protection of OSMA officers and employees from liability for actions performed in the course of their duties has also been expanded. These modifications reflect recent statutory changes in Chapter 1702 of the Ohio Revised Code that permit indemnification and protection of officers, employees and members of committees or commissions of the association. (See Chapters 1, Section 6 and 7; Chapter 11, Section 6; Chapter 15)

II. The Council recommends changes in the current membership classifications to separate and identify "Retired Members" and to establish a prerequisite for becoming a "Retired Member." This qualification requires prior active OSMA membership of at least ten (10) years. The Council restates the Council's right to set dues for all membership classes, now including retired and corporate, except active members. The Council proposes the elimination of the Life Active Members classification. Those who

OSMA Constitution and Bylaws

have already purchased Life Active Memberships will continue as active members. (See Article III and Chapter 1, Section 2)

III. The Council recommends that past presidents of the OSMA be considered delegates to the OSMA House with the right to vote. They presently have the privileges of the floor without the right to vote. (See Article IV)

IV. The Council recommends that all members of Council have a vote. Currently the representatives from the OSMA-HMSS Section, the Residents Section and Student Member Section are elected to non-voting seats on Council. The Council believes that every member of the Council should have the right to not only participate in the Council's deliberations, but also to vote on the issues discussed. (See Constitution — Article VII)

V. (a) The Council recommends changes in the Annual Meeting structure, which give the Delegates the flexibility to design the Annual Meeting to better meet their needs. The revision also eliminates the scientific program and the scientific sections, which have not been part of the Annual Meeting for several years. (Chapter 3, Section 3-9)

(b) The Council endorses the elimination of references in the OSMA Constitution and Bylaws to a scientific meeting and a scientific journal. The Council concluded from membership studies and its perceptions of members' needs that the OSMA no longer has a primary role in scientific education or producing scientific publications. The Council modified the purposes section of the Constitution to better reflect the priority activities of the

OSMA. (Article I, Section 2 (4) & (5))

(c) The Council recommends changing the required percentage of OSMA members in a specialty society necessary for the society to have a Delegate and Alternate Delegate to the OSMA House from the current floating figure to sixty percent (60%). Sixty percent (60%) is under the 1989 floating percentage. AMA currently requires a majority of a specialty society's membership to be AMA members or a minimum of 1,000 AMA members in the organization. (See Chapter 3 and Chapter 4, Section 3)

(d) The Council removed the specific Order of Business currently in the Constitution and replaced it with the Sturgis General Order of Business. The Order of Business can be modified before any session by the presiding officer with the consent of the House of Delegates. (See Chapter 3)

VI. The Council reviewed the duties and responsibilities of the officers, executive director and Council and redrafted parts of those sections to better represent the current administrative responsibilities and organizational activities of those individuals. (See Chapters 7,8 and 9)

VII. Council recommends giving the president the authority to create committees and task forces annually. The only mandated committees continued will be Judicial and Professional Relations, Auditing and Appropriations, Resolutions, Tellers and Judges, and Nominations. Other current committees may continue, depending on the needs of the OSMA membership as ascertained annually.

VIII. The Council revised the component societies section to permit individuals to be active members in multiple county societies. However, the revision does not permit these physicians to be counted in more than one (1) component society as an active member for OSMA House of Delegates representation. (See Chapter 11, Section 1)

IX. The Constitution and Bylaws have been rewritten in a gender neutral format pursuant to House of Delegates mandate. 1/17/91

RESOLUTION 1 FROM THE OSMA COUNCIL

WHEREAS, The OSMA Constitution and Bylaws have not been reviewed in their entirety for over twenty (20) years; and

WHEREAS, The needs and expectations of OSMA members have changed dramatically and will continue to change; and

WHEREAS, Meeting the changing needs of the members is the critical reason for the OSMA's continued existence; and

WHEREAS, The OSMA Constitution and Bylaws describe the organizational parameters of the OSMA necessary to meet the needs of the members; **therefore be it**

RESOLVED, That the House of Delegates approve the 1991 proposed amendments to the Constitution and Bylaws as follows:

CONSTITUTION AND BYLAWS
OF THE
OHIO STATE MEDICAL ASSOCIATION

CONSTITUTION

ARTICLE I
NAME AND PURPOSES

Section 1. Name. The name and title of this corporation shall be OHIO STATE MEDICAL ASSOCIATION.

Section 2. Purposes. The purposes of this Association shall be:

(1) To bring into one organization the physicians of the state of Ohio and through this, and similar societies of other states, to maintain and support the American Medical Association.

(2) To formulate and maintain educational programs designed to provide better service to the public in matters of personal and public health.

(3) To encourage among members of the medical profession the interchange of views on all phases of medical science, to the end that each member of the profession may be better equipped to serve society and promote the health of the public.

~~(4) To maintain programs of scientific education keyed to the constant advancement of the science of medicine and to foster, encourage, and coordinate post graduate educational facilities for the medical profession as a whole.~~

~~(5) To disseminate, among members of the profession, by means of scientific publications and otherwise, information reflecting advances in medical research.~~

(6) To maintain and advance the standards of medical practice in this state by requiring ~~strict~~ adherence by the members of the profession to the ~~highest~~ concepts of professional ethics.

(7) To study, ~~and~~ formulate methods of AND PROVIDE INFORMATION ON health care delivery ~~with particular emphasis on efficiency and availability~~ SYSTEMS.

(6) TO REPRESENT THE OPINIONS AND POLICY POSITIONS OF THE MEMBERS, AS APPROVED BY THE HOUSE OF DELEGATES OR THE COUNCIL, BEFORE GOVERNMENTAL BODIES AND AGENCIES.

(8) To carry on such functions and activities as are deemed necessary or desirable to effectuate the above purposes.

ARTICLE II
COMPONENT SOCIETIES

Section 1. Definition. Component societies shall consist of those county medical societies that now hold, or may hereafter receive, charters from this Association.

Section 2. Geographical Scope. Not more than one component society shall be chartered in any one county; provided, however, that a charter may be granted to a society comprising two or more counties, or parts thereof, when, in the judgment of the House of Delegates, the chartering of a multi-county society is in the best interests of this Association; and provided further, that whenever two or more component societies holding charters from this Association shall request in writing that they be organized into a single multi-county society, the House of Delegates may grant a charter to such ~~multi-county society, such multi-county society to WHICH SHALL be officially designated by hyphenating the names of the counties comprising such multi-county organization.~~

Section 3. Membership in Adjoining Society. If there ~~should be~~ IS an insufficient number of physicians in any county to form ~~themselves into~~ a component county society, such physicians may become members of the component society of an adjoining county, if they are otherwise eligible under the Constitution and Bylaws of such adjoining component society.

ARTICLE III
COMPOSITION OF THE ASSOCIATION

Section 1. Classes of Members. The Association shall consist of the following classes of members:

- 56 1. Active Members (~~including retired active members~~)
57
58 2. ~~Associate Members~~ RETIRED MEMBERS
59
60 3. Members in Training
61
62 4. Non-resident Members
63
64 5. Honorary Members
65
66 6. Military Members
67
68 7. Affiliate Members
69
70 8. Student Members.
71
72 9. Corporate Members
73

74 **Section 2. Voting Members.** The voting members of this Association shall consist of ~~each of~~ those physician
75 members of the component societies who ~~has~~ HAVE complied with the eligibility requirements of Chapter 1 of the
76 Bylaws of this Association, ~~and who has~~ HAVE been certified by the appropriate officer of his/HER component
77 society as being an Active Member, RETIRED MEMBER or a Member in Training in good standing of such society,
78 and whose dues and assessments in this Association for the current year have been received at the headquarters of this
79 Association; ~~provided, however, that~~ The foregoing provision regarding receipt of dues and assessments shall not
80 apply to members exempted from the payment of dues and assessments under the provisions of Chapter 2 of the
81 Bylaws of this Association, or to members whose dues and assessments have been waived.
82

83 ARTICLE IV 84 HOUSE OF DELEGATES 85

86 The House of Delegates shall be the legislative body of this Association and shall consist of: (1) delegates
87 elected by the component societies; (2) officers of the Association enumerated in Article VI AND PAST
88 PRESIDENTS OF THE ASSOCIATION WHO HAVE REGISTERED; (3) DELEGATES AND ALTERNATE
89 DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION FROM OHIO AND PAST COUNCILORS OF
90 THIS ASSOCIATION WHO SHALL BE EX-OFFICIO MEMBERS WITHOUT THE RIGHT TO VOTE UNLESS
91 SUCH PERSON IS ALSO A DULY ELECTED DELEGATE FROM A COMPONENT SOCIETY OR A DULY
92 ELECTED OFFICER OF THIS ASSOCIATION; AND (34) such representatives of other medical groups as may be
93 determined by the House of Delegates; INCLUDING THE FOLLOWING;
94

95 The Medical Student Section shall have ~~six~~ SEVEN (7) representatives to the House of Delegates ~~commencing~~
96 ~~with the Annual Meeting in 1982~~, said delegates to be selected in accordance with the Bylaws of the Medical Student
97 Section to be approved by Council. For purposes of representation in the House of Delegates, Student Members shall
98 not be counted at the individual district level, but shall constitute a separate section that shall be treated and seated as
99 if it were an additional district in which the Student Members of each OHIO medical AND OSTEOPATHIC
100 MEDICAL school elect their own delegates;
101

102 ~~†~~The Hospital Medical Staff Section shall have one representative to the House of Delegates ~~commencing with~~
103 ~~the Annual Meeting in 1985~~, said delegate to be selected in accordance with Bylaws of the Medical Staff Section to
104 be approved by Council;
105

106 (4)~~†~~The Resident Physician's Section shall have one representative who must be a Member in Training of the
107 OSMA, said representative to be ~~selected in accordance with the Resident Section bylaws to be approved by Council;~~
108 (5) delegates and alternate delegates to the American Medical Association from Ohio. Past Presidents and Past
109 Councilors of this Association each of whom shall be an ex-officio member without right to vote unless such
110 delegate, alternate delegate or past president be a duly elected delegate from a component society or a duly elected
111 officer of this Association.
112

113 THE PRIMARY MEDICAL SPECIALTIES LISTED BY THE AMERICAN BOARD OF MEDICAL
114 SPECIALTIES ARE ELIGIBLE TO HAVE A DELEGATE AND ALTERNATE DELEGATE TO BE SELECTED
115 IN ACCORDANCE WITH CHAPTER 4, SECTION 3 OF THE BYLAWS OF THIS ASSOCIATION.
116

117 ARTICLE V 118 MEETINGS 119

110 **Section 1. Annual Meeting.** This Association shall hold an Annual Meeting, ~~during which there shall be~~
111 ~~sessions of the House of Delegates, general sessions, meetings of specialty sections and meetings of specialty~~

societies, all of which shall be open to all registered members and registered guests.

Section 2. Time and Place of Annual Meeting. The time and place for holding each Annual Meeting shall be fixed by the Council of this Association.

Section 3. Special Meetings. Special meetings of the House of Delegates shall be called by the President or other officer upon a two-thirds vote of the Council or upon ~~the~~ filing, with the Executive Director of this Association, of a petition duly authorized and signed by the presidents of at least twenty-three (23) component societies. Within ten days after such action of the Council, or the filing of such petition, the Executive Director shall give written notice to the members of the House of Delegates, setting forth the purpose or purposes of such ~~called~~ meeting and specifying the time and place thereof, ~~which time of~~ IN NO EVENT SHALL THE meeting ~~shall in no event~~ be less than twenty (20) days nor more than sixty (60) days after the mailing of such written notice.

ARTICLE VI OFFICERS

Section 1. General. The officers of this Association shall be a President, a President-Elect, the Immediate Past President, a Secretary-Treasurer, and Councilors.

Section 2. Election and Eligibility. The officers of this Association shall be elected by the House of Delegates. ~~during the Annual Meeting.~~ No person shall be eligible for an elective office who has not been an ~~an~~ Active VOTING Member or ~~Member in Training~~ of this Association during the entire preceding two years. The terms of the officers of this Association shall be ~~such as are~~ prescribed by Chapter 6 of the Bylaws of this Association.

ARTICLE VII THE COUNCIL

~~The Council~~ THE BOARD OF TRUSTEES (REFERRED TO HEREIN AS "THE COUNCIL") shall consist of one Councilor from each Councilor district, one ~~non-voting~~ member from the Hospital Medical Staff Section, one ~~non-voting Councilor~~ MEMBER from the Resident Physician's Section, one ~~non-voting~~ Student Member from the Medical Student Section and the other elected officers of this Association. The Council shall be the executive body of this Association and ~~it~~ shall have the complete custody and control of all funds and property of this Association and shall have and exercise full power and authority of the House of Delegates between meetings of the House of Delegates.

ARTICLE VIII FISCAL YEAR

The fiscal year of this Association shall begin on January 1 and end on December 31.

ARTICLE IX SEAL

This Association shall have an official seal bearing the legend "Ohio State Medical Association - 1846." The power to change or renew the seal shall rest with the House of Delegates in conformity with the laws of the state of Ohio.

ARTICLE X REFERENDUM

By a two-thirds vote of the delegates present at a meeting of the House of Delegates, a general referendum shall be held upon any question then pending before it;

~~and~~ Upon a petition duly authorized and signed by the governing bodies of at least one-half of the component societies and filed with the Executive Director on or before the thirtieth (30th) day following the adjournment of a meeting of the House of Delegates, a general referendum shall be held upon any action taken at such meeting.

The procedure to be followed in connection with the submission to a referendum of any referred question or action shall be ~~that~~ AS set forth in Chapter 14 of the Bylaws of this Association; ~~provided, however, that if~~ IF the referred question ~~be IS with~~ IN respect to a proposed amendment to this Constitution, an affirmative vote of two-thirds (2/3) of those voting in such referendum shall be required to determine the referred question; ~~and provided, further, that~~ FURTHERMORE, if the referred action of the House of Delegates ~~be with~~ IS IN respect to the adoption by the House of Delegates of an amendment to this Constitution, a vote of two-thirds (2/3) of those voting in such referendum shall be required to reject and nullify the action of the House of Delegates in adopting such amendment.

ARTICLE XI

Section 1. Method of Amending. The House of Delegates may amend any article of this Constitution by a two-thirds (2/3) vote of the delegates and officers registered at the Annual Meeting or at any special meeting called for that purpose provided, however, that such proposed amendment shall have been published in BY The Journal of this Association, or sent by first class mail to all VOTING Members of the Association, at least sixty (60) THIRTY (30) days before such meeting and that a true and correct copy thereof shall have been sent by first class mail to the secretary of each component society at least thirty (30) days before each SUCH meeting.

Section 2. Conformity by Component Societies. When an amendment to this Constitution has been duly adopted, the secretary of each component society shall be notified in writing by the Executive Director within sixty (60) days after such amendment has become effective. It shall become incumbent upon each component society to make such change in its constitution and bylaws; or, if the society be a corporation, in its articles of incorporation and code of regulations or other fundamental body of rules for the government of the corporation, as will bring about conformity to the change in the Constitution of this Association. The secretary of such component society shall file with this Association a copy of such changes in the component society's constitution and bylaws together with written notice of compliance with the provisions of this section within one hundred and eighty (180) days after IT RECEIVES NOTICE. ~~notice shall have been given by the Executive Director to such component society.~~

ARTICLE XII

Upon the adoption of this Constitution by a two-thirds (2/3) vote of the delegates and officers present and voting, this Constitution will become effective and thereupon all previous Constitutions shall be rendered null and void of no effect.

BYLAWS

CHAPTER 1 MEMBERSHIP

Section 1. Rights of Members. All members in good standing of this Association shall have the right to attend all meetings of the Association. ~~and to take part in all the scientific proceedings of the Annual Meeting.~~

Section 2. Classification of Membership.

(a) Active Members. Active Members of this Association shall comprise all the active members in good standing of the several component societies. Active Members in good standing of this Association shall have the right to vote and hold office.

~~(b) Associate Members. Associate Members of this Association shall comprise all those members in good standing of the several component societies who hold an associate membership, or other probationary or provisional type of membership of limited duration, in a component society.~~ RETIRED MEMBERS. RETIRED MEMBERS OF THIS ASSOCIATION SHALL BE THOSE MEMBERS OF THIS ASSOCIATION WHO HAVE RETIRED FROM THE ACTIVE PRACTICE OF MEDICINE AND WHO ARE NOT ENGAGED IN ANY PROFESSIONAL ACTIVITY RELATED TO THE PRACTICE OF MEDICINE. THEY MUST BE RETIRED MEMBERS OF THEIR COMPONENT SOCIETY AND MUST HAVE BEEN ACTIVE MEMBERS OF THIS ASSOCIATION AND IN GOOD STANDING FOR TEN (10) YEARS PRIOR TO RETIREMENT. RETIRED MEMBERS SHALL HAVE THE RIGHT TO VOTE AND HOLD OFFICE.

(c) Members in Training. Members in Training shall comprise all those members in good standing of the several component societies who are pursuing studies and training in a program accredited by the American Medical Association OR THE AMERICAN OSTEOPATHIC ASSOCIATION and ~~its~~ THEIR associated groups. Members in training in good standing of this Association shall have the right to vote and hold office.

(d) Nonresident Members. Nonresident Members shall ~~also~~ include those physicians who reside and practice outside Ohio but who hold Ohio licenses to practice medicine and surgery and who are not eligible for membership in a component society of this Association and who are approved for Nonresident Membership by the Council.

(e) Honorary Members. The House of Delegates may elect as an Honorary Member any person distinguished for his services or attainments in medicine or the allied sciences or who has rendered other services of unusual value to medicine. An Honorary Member shall pay no dues or assessments.

(f) Military Members. Military Members comprise all those Active Members of this Association in good standing who are serving a limited tour of active duty with the Armed Services of the United States.

~~g) Life Active Members. Any Active Member of this Association who shall make a single payment of~~

~~\$3,000.00 for lifetime membership dues, shall become a Life Active Member of this Association and shall not be assessed additional membership dues during his lifetime. This membership shall be limited to the first 500 Active Members who make a single lifetime membership dues payment.~~

(hG) Affiliate Members. Executives of the Ohio State Medical Association, county medical societies, and other medical organizations and specialty societies in Ohio with three years or more experience in the sponsoring organization OR INDIVIDUALS RECOMMENDED BY A COMPONENT SOCIETY are eligible for Affiliate Membership in the Ohio State Medical Association. Such Affiliate Membership shall be at the ~~pleasure~~ DISCRETION of the Council. ~~An Affiliate Member shall pay no dues or assessments.~~

(hH) Student Members. Student Members of this Association shall comprise those students in good standing who are pursuing the diploma of Doctor of Medicine or Doctor of Osteopathy in an approved medical or osteopathic college or institution in the State of Ohio and are approved for Student Membership by the Council. Student Members shall comprise the medical group known as the Medical Student Section. Said section shall be governed by and operate under separate Bylaws approved by the Council. Except as otherwise provided in Article VII of the Constitution, Student Members in good standing of this Association shall have the right to vote and hold office in this Association.

(jI) Corporate Members. Medical partnerships and corporations, one or more of whose members or employees is an Active Member of this Association, are eligible for Corporate Membership in Ohio State Medical Association. Such Corporate Membership shall be at the ~~pleasure~~ DISCRETION of the Council. ~~A Corporate Member shall pay no dues or assessments and the privileges of a Corporate Member shall be determined by the Council.~~

Section 3. Eligibility. To be eligible for any class of membership other than honorary, affiliate, RETIRED, ~~or~~ student, OR CORPORATE in this Association, a person shall possess all of the following qualifications ~~to wit:~~

(a) ~~He~~ A PERSON must hold a limited, temporary, or unlimited certificate to practice medicine and surgery, or osteopathic medicine and surgery, issued by the licensing authority of the State of Ohio, which license must be in full force and effect at the time of ~~his~~ THE PERSON'S application for membership in this Association.

(b) ~~He~~ A PERSON must be a member in good standing of a component society.

Section 4. Disqualification. No person who is under sentence of suspension or expulsion from any component society of this Association, or whose name has been dropped from such society's roll of members, shall be entitled to any of the rights or benefits of this Association.

Section 5. Effect of Expiration, Revocation, or Termination of Certificate. Membership in this Association of a member in active practice whose certificate to practice medicine and surgery has expired, has been revoked, or has been otherwise terminated, shall be cancelled automatically as of the effective date of such expiration, revocation or termination. The provisions of this Section 5 shall not apply to members who have retired from active practice or to members whose certificate has been voluntarily surrendered due to illness, or to members whose license has automatically expired because of problems of communication.

Section 6. Disciplinary Procedure. Disciplinary action may be taken by this Association against a member of this Association only upon written charges signed by three or more members of this Association and filed with the Executive Director. STANDARD PROCEDURE FOR DISCIPLINARY ACTIONS REQUIRES THAT A COMPLAINT BE INITIALLY FILED WITH AND ADJUDICATED BY THE COMPONENT SOCIETY OF WHICH THE PHYSICIAN IS A MEMBER. As soon as possible, and in any event not later than ten (10) days after such filing, the Executive Director shall serve upon the accused member a true copy of such charges and shall also furnish to each member of the Council a copy thereof. Within thirty (30) days thereafter, the Council shall fix a time and place for a hearing on said charges and the Executive Director shall serve prompt written notice of such time and place upon the accused member and shall also furnish to each member of the Council a copy of such notice. Such hearing shall be held as soon as practicable but in no event sooner than twenty (20) days, or later than sixty (60) days, after the date of service of such notice upon the accused member. Service upon the accused of a copy of such charges or of such written notice, or both, may be made by delivering the same personally to the accused, or by sending the same both by registered mail and by regular mail addressed to the accused at his usual place of residence. At the hearing upon such charges the accused shall be afforded full opportunity to be heard in his own defense, to be represented by legal counsel of his own choosing, to cross examine the witnesses who testify against him, and to examine witnesses and offer evidence in his own behalf. The hearing shall be held and conducted in such manner as to ascertain all the facts fairly to the accused and this Association without requiring compliance with those formal or technical rules and requirements which ordinarily pertain to judicial proceedings.

~~Failure of the accused to appear or be represented at the hearing may be considered prima facie evidence of the truth of the charges.~~

~~A record shall be made of such hearing, and at the request of either the accused member or the Council, the~~

Executive Director shall cause a transcript to be made of the proceedings and evidence and shall furnish to the accused member upon request a copy of such record without charge to the accused member. Following the conclusion of the evidence, the Council shall hear arguments of the parties and their counsel and may permit or require the filing of briefs.

~~The accused member may appeal the decision of Council~~ (A) COUNCIL, UPON RECEIVING A WRITTEN CHARGE AS SET FORTH ABOVE, SHALL REFER THE REQUEST TO A STANDING OR AD HOC GRIEVANCE COMMITTEE. IF THE COMMITTEE, AFTER REVIEWING THE CHARGES, CONCLUDES THAT AN INVESTIGATION IS WARRANTED, IT SHALL CONDUCT AN INVESTIGATION. THE COMMITTEE SHALL PROCEED WITH THE INVESTIGATION IN A PROMPT MANNER. THE MEMBER SHALL BE NOTIFIED THAT AN INVESTIGATION IS BEING CONDUCTED AND SHALL BE GIVEN AN OPPORTUNITY TO PROVIDE INFORMATION IN A MANNER AND UPON SUCH TERMS AS THE COMMITTEE DEEMS APPROPRIATE. THE COMMITTEE MAY, BUT IS NOT OBLIGATED TO, CONDUCT INTERVIEWS WITH PERSONS INVOLVED. SUCH INVESTIGATION SHALL NOT CONSTITUTE A "HEARING" AS THAT TERM IS USED IN THESE BYLAWS. THE COMMITTEE SHALL CONSIDER THE FINDINGS OF THE INVESTIGATION AND DETERMINE WHETHER DISCIPLINARY ACTION IS ADVISABLE. THE COMMITTEE MAY, IN ITS DISCRETION, PROCEED FORWARD WITH THE DISCIPLINARY ACTION, DISMISS THE CHARGES, OR REFER THE CHARGES TO THE APPROPRIATE COMPONENT SOCIETY FOR HANDLING.

(B) IF THE GRIEVANCE COMMITTEE DETERMINES THAT DISCIPLINARY ACTION IS ADVISABLE, IT SHALL DIRECT THE EXECUTIVE DIRECTOR TO PROVIDE NOTICE TO THE MEMBER. THE NOTICE SHALL STATE THE ACTION PROPOSED TO BE TAKEN AGAINST THE MEMBER, THE REASONS FOR THE ACTION, THE RIGHT OF THE MEMBER TO REQUEST A HEARING WITHIN 30 DAYS OF THE DATE OF THE LETTER, AND A SUMMARY OF THE RIGHTS AND PROCEDURES TO BE FOLLOWED DURING THE HEARING. THE MEMBER SHALL HAVE 30 DAYS FOLLOWING THE MAILING OF THE NOTICE OF SUCH ACTION TO REQUEST A HEARING. THE REQUEST SHALL BE IN WRITING ADDRESSED TO THE EXECUTIVE DIRECTOR.

IF THE MEMBER DOES NOT REQUEST A HEARING WITHIN THE TIME AND MANNER DESCRIBED, THE MEMBER SHALL BE DEEMED TO HAVE WAIVED ANY RIGHT TO A HEARING AND TO HAVE ACCEPTED THE RECOMMENDATION INVOLVED. THE WRITTEN INVESTIGATION REPORT SHALL BE FORWARDED TO THE STANDING OR AD HOC COMMITTEE ON JUDICIAL AND PROFESSIONAL RELATIONS WHICH SHALL DETERMINE THE ACTION TO BE TAKEN. THE MEMBER UNDER THIS SECTION SHALL HAVE NO FURTHER RIGHTS TO HEARING OR APPEAL UNLESS THE ACTION TAKEN DIFFERS FROM THE RECOMMENDATION OF THE GRIEVANCE COMMITTEE.

(C) UPON RECEIPT OF A REQUEST FOR HEARING, THE MATTER SHALL BE REFERRED TO A STANDING OR AD HOC COMMITTEE ON JUDICIAL AND PROFESSIONAL RELATIONS OR A STANDING OR AN AD HOC COMMITTEE ON PEER REVIEW WHICH SHALL APPOINT A HEARING OFFICER TO CONDUCT THE HEARING WHO MAY BE ONE OF ITS MEMBERS. A HEARING SHALL BE SCHEDULED TO COMMENCE NOT LESS THAN 30 DAYS NOR MORE THAN 90 DAYS FROM THE DATE OF RECEIPT OF THE REQUEST FOR HEARING. THE EXECUTIVE DIRECTOR SHALL SEND THE MEMBER A NOTICE STATING THE PLACE, TIME, AND DATE OF THE HEARING AND A LIST OF THE WITNESSES, IF ANY, EXPECTED TO TESTIFY AT THE HEARING ON BEHALF OF THE GRIEVANCE COMMITTEE.

THE HEARING OFFICER SHALL ENDEAVOR TO ENSURE THAT ALL PARTICIPANTS IN THE HEARING HAVE A REASONABLE OPPORTUNITY TO BE HEARD AND TO PRESENT RELEVANT ORAL AND DOCUMENTARY EVIDENCE IN AN EFFICIENT AND EXPEDITIOUS MANNER, AND THAT PROPER DECORUM IS MAINTAINED. THE HEARING OFFICER SHALL BE ENTITLED TO DETERMINE THE ORDER OF, OR PROCEDURE FOR, PRESENTING EVIDENCE AND ARGUMENTS DURING THE HEARING AND SHALL HAVE THE AUTHORITY AND DISCRETION TO MAKE ALL RULINGS ON QUESTIONS WHICH PERTAIN TO MATTERS OF LAW, PROCEDURE OR THE ADMISSIBILITY OF EVIDENCE. IF THE HEARING OFFICER DETERMINES THAT EITHER SIDE IN A HEARING IS NOT PROCEEDING IN AN EFFICIENT AND EXPEDITIOUS MANNER, THE HEARING OFFICER MAY TAKE SUCH DISCRETIONARY ACTION AS SEEMS WARRANTED BY THE CIRCUMSTANCES.

THE HEARING OFFICER MAY, BUT SHALL NOT BE REQUIRED TO, ORDER THAT ORAL EVIDENCE BE TAKEN ONLY ON OATH ADMINISTERED BY ANY PERSON LAWFULLY AUTHORIZED TO ADMINISTER SUCH OATHS. JUDICIAL RULES OF EVIDENCE AND PROCEDURE RELATING TO THE CONDUCT OF THE HEARING, THE EXAMINATION OF WITNESSES, AND THE PRESENTATION OF EVIDENCE SHALL NOT APPLY TO A HEARING CONDUCTED UNDER THESE BYLAWS. ANY RELEVANT EVIDENCE, INCLUDING HEARSAY, SHALL BE ADMITTED IF IT IS THE SORT OF EVIDENCE UPON WHICH REASONABLE PEOPLE ARE ACCUSTOMED TO RELY IN THE CONDUCT OF SERIOUS AFFAIRS, REGARDLESS OF THE ADMISSIBILITY OF SUCH EVIDENCE IN THE COURT OF LAW. THE HEARING OFFICER MAY INTERROGATE THE WITNESSES OR CALL ADDITIONAL

376 WITNESSES IF THE HEARING OFFICER DEEMS SUCH ACTION APPROPRIATE.

377
378 (D) BOTH THE MEMBER AND THE GRIEVANCE COMMITTEE HAVE THE RIGHT TO BE
379 REPRESENTED IN ANY PHASE OF THE HEARING OR PRELIMINARY PROCEDURES BY AN ATTORNEY
380 AT LAW OR BY ANY OTHER PERSON OF THAT PARTY'S CHOICE; TO HAVE A RECORD MADE OF THE
381 PROCEEDINGS, COPIES OF WHICH MAY BE OBTAINED BY THE MEMBER UPON PAYMENT OF ANY
382 REASONABLE CHARGES ASSOCIATED WITH THE PREPARATION THEREOF; THE GRIEVANCE
383 COMMITTEE, THE ACCUSED, LEGAL COUNSEL FOR THE ACCUSED OR THE GRIEVANCE COMMITTEE
384 OR ANY OTHER PERSON OF EITHER PARTY'S CHOICE SHALL HAVE THE RIGHT TO CALL, EXAMINE,
385 CROSS-EXAMINE, AND IMPEACH WITNESSES; TO PRESENT EVIDENCE DETERMINED TO BE
386 RELEVANT BY THE HEARING OFFICER, REGARDLESS OF ITS ADMISSIBILITY IN A COURT OF LAW;
387 AND TO SUBMIT A WRITTEN STATEMENT AT THE CLOSE OF THE HEARING.

388
389 UNLESS OTHERWISE DETERMINED FOR GOOD CAUSE, THE GRIEVANCE COMMITTEE SHALL
390 HAVE THE INITIAL DUTY TO PRESENT EVIDENCE FOR EACH CASE OR ISSUE IN SUPPORT OF THE
391 PROPOSED ACTION OR RECOMMENDATION. THE MEMBER SHALL BE OBLIGATED TO PRESENT
392 EVIDENCE IN RESPONSE. THROUGHOUT THE HEARING, THE GRIEVANCE COMMITTEE SHALL BEAR
393 THE BURDEN OF PERSUADING THE HEARING OFFICER, BY A PREPONDERANCE OF THE EVIDENCE,
394 THAT THE ACTION OR RECOMMENDATION IS REASONABLE AND WARRANTED.

395
396 FAILURE WITHOUT GOOD CAUSE OF THE MEMBER TO PERSONALLY ATTEND THE HEARING
397 SHALL BE DEEMED TO CONSTITUTE ACCEPTANCE OF THE DISCIPLINARY ACTION INVOLVED, AND
398 A WAIVER OF THE RIGHT TO A HEARING. POSTPONEMENTS AND EXTENSIONS OF THE TIME
399 BEYOND THE TIME FOR HEARING PERMITTED IN THESE BYLAWS MAY BE PERMITTED BY THE
400 HEARING OFFICER, WITHIN HIS/HER DISCRETION ON A SHOWING OF GOOD CAUSE.

401
402 (E) THE RECOMMENDATION OF THE HEARING OFFICER SHALL BE BASED ON THE EVIDENCE
403 INTRODUCED AT THE HEARING, INCLUDING ALL LOGICAL AND REASONABLE INFERENCES FROM
404 THE EVIDENCE AND THE TESTIMONY. WITHIN 30 DAYS AFTER THE FINAL ADJOURNMENT OF THE
405 HEARING, THE HEARING OFFICER SHALL RENDER A RECOMMENDATION WHICH SHALL BE
406 ACCOMPANIED BY A REPORT IN WRITING STATING THE REASONS FOR THE RECOMMENDATION.
407 THE REPORT AND RECOMMENDATION SHALL BE DELIVERED TO THE COMMITTEE ON JUDICIAL
408 AND PROFESSIONAL RELATIONS AND TO THE MEMBER. AT ITS NEXT REGULAR MEETING AFTER
409 RECEIPT OF THE REPORT AND RECOMMENDATION, OR AS SOON THEREAFTER AS IS PRACTICABLE,
410 THE COMMITTEE ON JUDICIAL AND PROFESSIONAL RELATIONS SHALL CONSIDER THE REPORT,
411 RECOMMENDATION, AND ANY OTHER RELEVANT INFORMATION. IT SHALL THEN MAKE A FINAL
412 DECISION REGARDING THE PROPOSED DISCIPLINARY ACTION, AND NOTIFY COUNCIL OF ITS
413 DECISION. FOLLOWING THE DECISION, THE EXECUTIVE DIRECTOR SHALL FORWARD TO THE
414 MEMBER THE WRITTEN DECISION OF THE ~~PEER REVIEW~~ COMMITTEE, INCLUDING A STATEMENT
415 OF THE BASIS FOR THE DECISION.

416
417 (F) ANY MEMBER AGAINST WHOM DISCIPLINARY ACTION HAS BEEN TAKEN PURSUANT TO
418 THESE BYLAWS SHALL HAVE THE RIGHT OF APPEAL TO COUNCIL. SUCH APPEAL MUST BE
419 COMMENCED BY A WRITTEN NOTICE DIRECTED TO THE EXECUTIVE DIRECTOR WITHIN 30 DAYS
420 AFTER THE DATE ON WHICH THE NOTICE OF FINAL DECISION WAS MAILED TO THE MEMBER.

421
422 UPON RECEIPT OF NOTICE OF APPEAL, COUNCIL SHALL ~~APPOINT THREE MEMBERS OF~~
423 ~~COUNCIL TO~~ SERVE AS THE APPELLATE PANEL. THE MEMBER APPEALING SHALL SUBMIT A
424 WRITTEN STATEMENT DISCUSSING THE RELEVANT FACTS AND ISSUES. WITHIN 20 DAYS
425 FOLLOWING THIS SUBMISSION OF THE MEMBERS' WRITTEN STATEMENT, THE GRIEVANCE
426 COMMITTEE MAY SUBMIT A WRITTEN RESPONSE TO THAT STATEMENT. THE MEMBER MAY
427 SUBMIT A WRITTEN REPLY WITHIN TEN DAYS FOLLOWING THE SUBMISSION OF THE GRIEVANCE
428 COMMITTEE'S RESPONSE.

429
430 ~~THE APPELLATE PANEL~~ THE COUNCIL MAY, UPON ITS OWN MOTION OR REQUEST BY THE
431 MEMBER OR GRIEVANCE COMMITTEE, SCHEDULE ORAL ARGUMENTS UPON THE ISSUES RAISED IN
432 THE APPEAL. THE ORAL ARGUMENTS, IF SCHEDULED, SHOULD BE HELD WITHIN 20 DAYS
433 FOLLOWING THE SUBMISSION OF THE FINAL WRITTEN BRIEF.

434
435 ~~THE APPELLATE PANEL~~ COUNCIL SHALL, WITHIN 20 DAYS AFTER THE ORAL ARGUMENTS OR
436 THE FINAL WRITTEN SUBMISSION IF ORAL ARGUMENTS ARE NOT CONDUCTED, RENDER A
437 WRITTEN OPINION SETTING FORTH ITS DECISION WHETHER TO ACCEPT, REJECT OR MODIFY THE
438 DECISION OF THE ~~PEER REVIEW~~ JUDICIAL AND PROFESSIONAL RELATIONS COMMITTEE STATING
439 THE BASIS FOR ITS DECISION. THE EXECUTIVE DIRECTOR SHALL FORWARD A COPY OF THE
440 DECISION TO THE MEMBER, THE GRIEVANCE COMMITTEE AND THE ~~PEER REVIEW~~ JUDICIAL AND
441 PROFESSIONAL RELATIONS COMMITTEE.

(G) THE ACCUSED MEMBER MAY APPEAL THE DECISION OF THE APPELLATE COUNCIL on questions of law and procedure, but not of fact, to the Judicial Council of the AMA by filing a notice of appeal with the Judicial Council within thirty days of the decision of Council, such appeal to be governed by the rules and regulations of the Judicial Council. ~~The decision of Council shall be final pending an appeal to the Judicial Council.~~

(H) AFTER FINAL ACTION HAS BEEN TAKEN PURSUANT TO SUBDIVISION (B) OR (E) OF THIS SECTION, AND THE MEMBER HAS EITHER WAIVED OR EXHAUSTED THE RIGHT TO APPEAL TO THE APPELLATE PANEL OF COUNCIL AND THE RIGHT TO APPEAL TO THE AMA, THE EXECUTIVE DIRECTOR SHALL REPORT THE ACTION TO STATE AND FEDERAL AUTHORITIES AS REQUIRED BY OHIO REVISED CODE 4731.224, AND THE HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986 (PUBLIC LAW 99-660, TITLE IV AND 45 CFR PART 60).

Section 76. Limitation of Liability. No member, AGENT or employee serving on a utilization committee, a peer review or professional standards review committee, ~~which includes~~ ANY PERSON participation in the context of ~~this~~ THE PROCESS SET FORTH IN THE disciplinary Chapter, of this Association shall be deemed liable in damages to any person for any action taken or recommendation made within the scope of the functions of said committee, if such committee member, AGENT or employee acts without malice and in the reasonable belief that such action or recommendation is warranted by the facts known to ~~him~~ THE PERSON after reasonable effort to obtain the facts of the matter as to which such action is taken or recommendation is made. NO PERSON AGAINST WHOM DISCIPLINARY ACTION IS INSTITUTED PURSUANT TO THE DISCIPLINARY CHAPTER OF THESE BYLAWS SHALL HAVE ANY CLAIM OR CAUSE OF ACTION AGAINST THIS ASSOCIATION, OR AGAINST ANY OFFICER, COUNCILOR, MEMBER, AGENT OR EMPLOYEE OF THIS ASSOCIATION, BY REASON OF THE INSTITUTION, PROSECUTION, OR DISPOSITION OF SUCH CHARGES OR THE HEARING OR CONSIDERATION THEREOF.

CHAPTER 2

DUES AND ASSESSMENTS

Section 1. Determination of Dues. The annual dues and assessments of Active Members ~~and Associate Members~~ of this Association shall be determined by the House of Delegates, and shall be levied per capita on such members. They shall be payable before January 1, of the calendar year for which such dues are levied. The dues and assessments ~~shall be collected by the designated officer of each component society and~~ shall be forwarded to the headquarters of this Association, together with such data as shall be required by this Association for its own record. ~~of such society's officers and membership.~~

The Council of this Association shall have the authority to promulgate regulations governing the amount of annual dues and assessments of all classifications of members other than Active ~~and Associate~~. A physician who is not engaged in active practice because of disability ~~or the infirmities of age~~ and who was a member in good standing of this Association at the time of ~~his retirement from active practice shall~~ THE DISABILITY MAY be exempt from the payment of dues and assessments in this Association, provided ~~he~~ THE MEMBER'S ANY requests FOR such exemption FROM DUES AND ASSESSMENTS ~~and such request~~ is approved in writing by the secretary of ~~his~~ THE MEMBER'S component society.

A member of this Association for whom payment of ~~his~~ THE MEMBER'S regular dues ~~in this Association~~ constitutes a financial hardship may SUBMIT A request TO the Council of this Association for an adjustment of dues. Such request shall be in writing, signed by ~~such~~ THE member and filed with the secretary of ~~such~~ THE member's component society. If such society, or the council of such society, finds that payment by ~~such~~ THE member of ~~his~~ regular dues in this Association shall constitute a financial hardship and certifies ~~such~~ THE finding to the Council of this Association, the Council of this Association will make ~~such~~ AN adjustment of ~~his~~ THE MEMBER'S OSMA dues for such period of time, and subject to such conditions, as ~~such~~ OSMA Council may deem appropriate and advisable.

Section 2. Receipt of Dues, Qualifying Membership. The record of payment of dues and assessments on file in the offices of this Association shall be evidence of the fact of payment by a member and of ~~his~~ THAT MEMBER'S right to attend all meetings of the Association. ~~and to participate in all the scientific proceedings of the Annual Meeting.~~

Section 3. Arrears In Membership. A member of this Association whose dues and assessments in this Association shall not have been paid ~~to the secretary of his component society~~ on or before January 1 of any year shall be deemed delinquent from January 1 of such year and until such dues and assessments have been paid.

Section 4. Penalty for Failure to Remit. Any component society which fails to forward to the headquarters of this Association on or before the thirtieth (30th) day preceding the Annual Meeting such dues and assessments of this Association as the society may have collected shall be subject to the suspension of all its rights and privileges under its charter, ~~in which case~~ AND none of its members or delegates shall be permitted to participate in any of the

proceedings of this Association or of the House of Delegates.

Section 5. Exemption from Dues and Assessments. The provisions of Section 2 and 3 of this Chapter shall not apply to members exempted from the payment of dues and assessments, or to members whose dues and assessments are waived.

CHAPTER 3 ANNUAL MEETING

Section 1. Functions of Annual Meeting. The Annual Meeting of the Association will be held as provided in Article V of the Constitution. ~~This shall encompass the Scientific Assembly, the House of Delegates meetings and such other functions as may be determined by the Council.~~

Section 2. Registration. Each member in attendance at the Annual Meeting shall register, after his THE MEMBER'S status as a member in good standing has been verified by reference to the records of this Association. ~~The name of a physician upon the membership roster of this Association shall be prima facie evidence of his right to register.~~

No member or delegate shall take part in any of the proceedings of the Annual Meeting until he THAT MEMBER OR DELEGATE has registered.

~~**Section 3. Scientific Program.** The Scientific Assembly shall meet in such general sessions and such section sessions during the Annual Meeting as may be determined by the Committee on Education with the approval of the Council.~~

~~**Section 4. Section Officers.** Each section shall elect a chairman CHAIR and a secretary to serve until their successors are elected. They shall serve as ex officio members of the Committee on Education provided for in Section 4 of Chapter 9 of these Bylaws.~~

~~If for any reason a section shall fail to elect section officers at a section session held during the Annual Meeting, such officers shall be appointed by the Council at its first meeting following the close of the Annual Meeting.~~

~~**Section 5. Section Sessions.** Each section authorized by the Council shall hold its session or sessions at times determined by the Council but no section session shall be held at the same time as a general session.~~

~~**Section 76. Section Rules.** Rules adopted by a section must not be in conflict with the Constitution and Bylaws of this Association and must be approved by the Council before becoming effective.~~

~~**Section 67. Acceptance of Papers.** The papers and discussions in section meetings shall be limited to scientific subjects. No paper shall be presented before a section unless an abstract of such paper, containing not less than thirty (30) and not more than one hundred and fifty (150) words, be in the hands of the Committee on Education at least thirty (30) days before the first day of the Annual Meeting.~~

~~**Section 8. Time Limit of Papers.** The Committee on Education shall each year fix a time limit for the delivery of each paper.~~

~~**Section 9. Papers shall be the Property of the Association.** All papers read before this Association shall be its property and immediately after being read shall be deposited with the secretary of the section, if read before a section, or with the Executive Director, if read before a general session. Unless express consent of the Council is first obtained, no member shall cause a paper read before this Association, or any part, abstract or summary thereof, to be published elsewhere prior to publication in the official Journal of this Association; and each guest speaker invited to read or deliver a paper on a medical or scientific subject shall be expected to agree, at the time of his THE GUEST SPEAKER'S acceptance of such invitation, to refrain from causing such paper to be published elsewhere prior to publication in such Journal. These papers shall be released to the author by the Editor of The Journal if he THE AUTHOR has not stated, within a period of six (6) months after submission, his intent to publish them THE PAPER.~~

CHAPTER 4 THE HOUSE OF DELEGATES

Section 1. Meetings of the House of Delegates. The House of Delegates shall meet annually at the time and place of the Annual Meeting of this Association. All sessions of the House of Delegates ~~shall be~~ ARE open to all members in good standing of this Association.

Section 2. Ratio of Representation. Each component society shall be entitled to one delegate in the House of Delegates for each one hundred (100) ~~Active~~ DUES PAYING VOTING Members, ~~Associate Members, and Members in Training, or fraction thereof,~~ in good standing in this Association; provided, however, that each component society

574 shall be entitled to at least one delegate and one alternate delegate. IF THE TOTAL NUMBER OF DUES PAYING
575 VOTING MEMBERS OF THE COMPONENT SOCIETY IS NOT EVENLY DIVISIBLE BY ONE HUNDRED
576 (100), THAT COMPONENT SOCIETY SHALL BE ENTITLED TO ONE ADDITIONAL DELEGATE IN THE
577 HOUSE OF DELEGATES. The names of such delegates and alternate delegates shall be submitted to the
578 headquarters of this Association at least ~~thirty (30)~~ SIXTY (60) days prior to the first day of the meeting of the House
579 of Delegates.
580

581 In case a delegate or alternate delegate of a component society is unable to serve, the president or secretary of
582 such society may at any time certify to the ~~Chairman~~ CHAIR of the Committee on Credentials the name of an ~~Active~~
583 VOTING Member ~~or Member in Training~~ in good standing to serve in the place of such absent delegate or absent
584 alternate delegate. The Committee on Credentials shall rule on the eligibility of such certified individual or
585 individuals to act in the place ~~and stand~~ of such absent delegate or alternate delegate.
586

587 **Section 3. Representation of Medical Specialties.** All primary medical specialties listed by the American
588 Board of Medical Specialties are eligible ~~to apply~~ for representation in the House of Delegates. ~~IF To be eligible, the~~
589 ~~specialty society or societies in the section initially must have HAS 50% 60% of their physicians as members of the~~
590 ~~OSMA. At the end of its third year of representation, its percentage of OSMA membership must equal the~~
591 ~~percentage of the total physician population in Ohio who are members of OSMA, calculated as of January 31, each~~
592 ~~year. If for 3 consecutive years thereafter this percentage is not maintained, then delegate status is terminated.~~
593

594 A Medical Specialty ~~Section~~ SOCIETY seeking representation shall apply to the Council. The Council shall
595 consider applications and then recommend to the House of Delegates whether the specialty society qualifies for
596 representation.

597 Each recognized Medical Specialty ~~Section~~ SOCIETY shall have one delegate and ONE alternate DELEGATE
598 who must be VOTING Members of the Ohio State Medical Association. Each specialty ~~section~~ SOCIETY will
599 certify to the Association at least 60 days prior to the Annual Meeting both the names of its delegate and alternate,
600 and its membership certification as required ~~by subsection (b) above.~~ IN CASE A DELEGATE OR ALTERNATE
601 DELEGATE IS UNABLE TO SERVE, THE PRESIDENT OF THE RECOGNIZED MEDICAL SPECIALTY
602 SOCIETY MAY AT ANY TIME CERTIFY TO THE CHAIR OF THE COMMITTEE ON CREDENTIALS THE
603 NAME OF A VOTING MEMBER OF THE ASSOCIATION TO SERVE IN PLACE OF THE ABSENT
604 DELEGATE OR ABSENT ALTERNATE DELEGATE. THE COMMITTEE ON CREDENTIALS SHALL RULE
605 ON THE ELIGIBILITY OF SUCH CERTIFIED INDIVIDUAL OR INDIVIDUALS TO ACT IN THE PLACE OF
606 SUCH ABSENT DELEGATE OR ALTERNATE DELEGATE. A Medical Specialty ~~Section~~ SOCIETY delegate
607 shall have all rights, privileges and duties as other delegates. The delegate will be seated in the House of Delegates
608 with the Councilor District in which ~~his/her~~ THAT DELEGATE'S county medical society is represented.
609

610 ~~Failure to comply with Section 3, Chapter 4 shall result in loss of representation. That determination shall be~~
611 ~~made by the Council, with appeal provided to the House of Delegates.~~
612

613 **Section 4. Resident Section.** The Resident Section shall have one delegate and one alternate delegate who must
614 be Members in Training of the OSMA. The Resident Physician Section's delegates shall have all the rights,
615 privileges, and duties of other delegates. The delegate will be seated in the House of Delegates with THE Councilor
616 District in which ~~his/her~~ THAT DELEGATE'S county medical society is represented.
617

618 **Section 5. Representative of Hospital Medical Staff Section.** The Hospital Medical Staff Section shall have
619 one delegate and alternate delegate who must be ~~Active~~ VOTING Members of the Ohio State Medical Association.
620 In case a delegate or alternate delegate is unable to serve, the ~~Chairman~~ CHAIR of the Section may at any time certify
621 to the ~~Chairman~~ CHAIR of the Committee on Credentials the name of an ~~Active~~ VOTING Member of the
622 Association to serve in place of the absent delegate or absent alternate delegate. The Committee on Credentials shall
623 rule on the eligibility of such certified individual or individuals to act in the place ~~and stand~~ of such absent delegate or
624 alternate delegate. The Hospital Medical Staff Section delegate shall have all rights, privileges and duties of other
625 delegates. The delegate will be seated in the House of Delegates with the Councilor District in which ~~his/her~~ THAT
626 DELEGATE'S county medical society is represented.
627

628 **SECTION 6. MEDICAL STUDENT SECTION.** THE MEDICAL STUDENT SECTION SHALL HAVE
629 ONE DELEGATE AND ONE ALTERNATE DELEGATE SELECTED FROM EACH OF THE SIX MEDICAL
630 COLLEGES AND THE ONE OSTEOPATHIC MEDICAL COLLEGE IN THE STATE OF OHIO PURSUANT TO
631 THE MEDICAL STUDENT SECTION BYLAWS. THE MEDICAL STUDENT SECTION DELEGATES SHALL
632 HAVE ALL THE RIGHTS, PRIVILEGES AND DUTIES OF OTHER DELEGATES. THE SEVEN (7)
633 DELEGATES WILL BE SEATED IN THE HOUSE OF DELEGATES AS A SEPARATE SECTION WHICH
634 SHALL BE SEATED AS AN ADDITIONAL DISTRICT.
635

636 **Section 67. Quorum.** A majority of registered delegates and officers of this Association shall constitute a
637 quorum.
638

639 **Section 78. Committees of the House of Delegates.** For the purpose of expediting proceedings the President

shall appoint from the roster of delegates the following reference committees: ~~Committee on President's Address;~~
Committees on Resolutions, to which shall be referred all resolutions (except those of an ethical nature involving the
professional relations of individual physicians or groups of physicians); Committee on Credentials; and other
committees considered necessary by the President.

The President shall appoint from the roster of alternate delegates the Committee on Tellers and Judges of
Election.

Section 89. Delegates to the American Medical Association. The House of Delegates shall elect
representatives to the House of Delegates of the American Medical Association in accordance with the constitution
and bylaws of that body, except for one alternate delegate, who shall be elected by the Medical Student Section in
accordance with the constitution and bylaws of this Association and the bylaws of the Medical Student Section.

Section 910. Councilor Districts. The House of Delegates shall establish Councilor Districts. The districts
shall comprise one or more contiguous counties. A district society may be organized in any of the Councilor Districts
to meet at such time or times as such society may fix.

Section 4011. Special Committees. Any Voting Member ~~who is in good standing in~~ OF this Association may
be appointed to serve on any committee created for a special purpose. All members of committees who are not
members of the House of Delegates shall have the right to present their reports to the House in person and to
participate in the debate thereon, but shall not have the right to vote.

Section 412. Resolutions. Except as otherwise provided, ~~under Section 12,~~ every resolution to be presented to
the House of Delegates for action shall be filed with the Executive Director of the Association at least sixty (60) days
prior to the first day of the meeting at which action on such resolution is proposed to be taken; and promptly upon the
filing of any such resolution the Executive Director shall prepare and transmit a copy thereof to each member of the
House of Delegates. Each resolution which, if adopted, would require expenditure of funds by the Association, shall
have attached, a statement of the amount of the estimated annual expenditure. The Executive Director shall cause to
be published in ~~The Journal in~~ advance of such meeting of the House of Delegates such resolutions as the President or
the Council may designate.

No resolution may be presented or introduced at any meeting of the House of Delegates, unless the foregoing
requirements for filing and transmittal shall have been complied with, or unless such compliance shall have been
waived under Section 12; OR by a Special Committee on Emergency Resolutions named to decide whether late
submission was justified. LATE SUBMISSION IS ONLY JUSTIFIED WHEN EVENTS GIVING RISE TO THE
RESOLUTION OCCUR AFTER THE FILING DEADLINE FOR RESOLUTIONS. This special committee shall
consist of the chairmen of the several resolution committees. If a majority of the members of the Special Committee
on Emergency Resolutions vote favorably for waiving the filing and transmittal requirement, then such resolution
shall be presented to the House of Delegates at its opening session. All resolutions presented subsequent to the 60-
day filing date prior to the opening session of the House of Delegates shall be submitted by their sponsors to the
committee no less than 12 hours prior to the opening session of the House of Delegates. IF THE COMMITTEE
VOTES UNFAVORABLY, THE HOUSE MAY OVERRIDE THE COMMITTEE'S RECOMMENDATION BY
AN AFFIRMATIVE VOTE OF 4/5 OF THE DELEGATES VOTING.

No consideration may be given, or any action taken, by the Committee on Resolutions or by the House of
Delegates, with respect to any resolution unless such resolution ~~shall have been~~ IS presented or introduced at the
opening session of the meeting of the House of Delegates; ~~provided, However, that~~ a resolution dealing with an
event or development occurring too late to permit the introduction of any such resolution at the opening session may
be introduced at a later session with the consent of at least four-fifths (4/5) of the delegates present; ~~and~~ Upon its
introduction, such resolution shall be referred to the Committee on Resolutions for consideration and report; ~~and,~~
~~provided further, that~~ The Committee on Resolutions shall have the right to amend any SUCH resolution presented or
introduced, or to draft a composite or substitute resolution embracing the same subject matter as ~~that contained in a~~
THE resolution or resolutions ~~presented or~~ introduced, and to submit such amended, composite or substitute
resolution for adoption by the House of Delegates; ~~and,~~ The House of Delegates shall have the right to adopt any
such amended, composite or substitute resolution.

Any resolution adopted by the House of Delegates ~~in 1979 and thereafter~~ will become null, void and of no effect
if not re-proposed and re-adopted within four years from the effective date of the adoption of the Resolution. Within
the fourth year of their effective date, the House of Delegates will be notified ~~by January 31 in writing~~ of those
resolutions subject to re-adoption at the Annual Meeting at which they will be considered.

Section 4213. Hospital Medical Staff Section Resolutions. A maximum of five resolutions, directly related to
issues of concern to physicians on Hospital Medical Staffs and matters of immediate importance, adopted by and
presented from the business meeting of the hospital medical staff section representative assembly, as provided in their
bylaws, may be presented for consideration by the ~~h~~House of ~~d~~Delegates at any time before the opening of the

706 ~~H~~House of ~~d~~Delegates. All other resolutions adopted by and presented from the business meeting of the
707 Representative Assembly of the Hospital Medical Staff Section shall be submitted in report form to the House of
708 Delegates at the Annual Meeting of the House of Delegates for THE purpose of filing.
709

710 **Section 1314. Order of Business.** ~~The following shall be the order of business for the opening and final~~
711 ~~sessions of the House of Delegates.~~ THE ORDER OF BUSINESS OF THE HOUSE OF DELEGATES SHALL BE
712 ACCORDING TO THE STURGIS STANDARD CODE OF PARLIAMENTARY PROCEDURE.
713

714 **A. Opening Session.**

715
716 1. ~~Call to order by the President.~~

717
718 2. ~~Report of Committee on Credentials.~~

719
720 3. ~~Consideration of minutes of last Annual Meeting and of minutes of any special meeting of the House of~~
721 ~~Delegates held since the last Annual Meeting.~~

722
723 4. ~~Introduction of special guests.~~

724
725 5. ~~Appointment of Reference Committees by the President.~~

726
727 6. ~~Election of Committee on Nominations.~~

728
729 7. ~~Report of Special and Standing Committees.~~

730
731 8. ~~President's Address.~~

732
733 9. ~~Introduction of Presidents of other State Societies~~

734
735 10. ~~President Elect's Address.~~

736
737 11. ~~Introduction of Resolutions.~~

738
739 12. ~~Miscellaneous business.~~

740
741 **B. Final Session.**

742
743 1. ~~Report of Committee on Credentials.~~

744
745 2. ~~Election of President Elect.~~

746
747 3. ~~Report of Committee on Nominations; and election of other officers.~~

748
749 4. ~~Reports of Reference Committees.~~

750
751 5. ~~Miscellaneous business.~~

752
753 6. ~~Installation of officers.~~

754
755 7. ~~Unfinished business.~~

756
757 8. ~~Adjournment.~~

758
759 The order of business may be modified for any session by the presiding officer with consent of the House of
760 Delegates.
761

762 **CHAPTER 5**
763 **NOMINATION AND ELECTION OF OFFICERS**
764

765 **Section 1. Committee on Nominations.** On the first day of the Annual Meeting the House of Delegates shall
766 elect a Committee on Nominations consisting of one delegate from each Councilor District. The ~~chairmanship~~
767 CHAIR of the Committee on Nominations shall be rotated in numerical order annually among the Councilor District
768 representatives on such Committee. The Committee on Nominations shall report to the House of Delegates a ticket
769 containing the name of one or more members for each of the offices to be filled at that Annual Meeting, except that of
770 President-Elect. Prior to selecting a ticket the Committee shall hold hearings which shall be open to all members in
771 good standing of this Association. Any member in good standing shall have the opportunity to appear before the

Committee regarding any proposed candidate. The Committee may request an interview with any proposed candidate or with any member concerning such proposed candidate's qualifications. Each nominee must have a majority vote of the Committee in order to be placed on the ticket for presentation to the House of Delegates. Each nominee for Councilor must be a resident of the Councilor District for which ~~he~~ THAT COUNCILOR is nominated. Delegates and Alternate Delegates to the American Medical Association shall be elected at large.

Section 2. Eligibility for Reelection of Officers, Delegates and Alternate Delegates to the American Medical Association. No Past President of this Association shall be eligible for election as President-Elect. No Secretary-Treasurer shall serve for more than two consecutive terms. No Councilor shall serve in such capacity for more than three consecutive terms. Any officer originally elected to serve a year or less of an unexpired term shall not be regarded thereby as having served a term. Nothing in these Bylaws shall be construed as forbidding later reelection to any office, other than that of President or President-Elect, after an interruption in consecutive service.

Section 3. Nomination of President-Elect. Nominations for the office of President-Elect shall be made from the floor of the House of Delegates; provided, however, that only those candidates may be nominated whose names have been filed with the Executive Director ~~at the time and in the manner hereinafter~~ AS HEREIN provided, unless compliance with such requirements shall be waived, ~~as hereinafter provided~~. The name of a candidate for the office of President-Elect must be filed with the Executive Director of the Association at least sixty (60) days prior to the meeting of the House of Delegates at which the election is to take place. ~~Promptly~~ Upon the filing of such candidate's name, the Executive Director shall prepare and transmit PROMPTLY this information to each member of the House of Delegates. ~~No nomination for President-Elect may be presented at any meeting of the House unless the foregoing requirements of filing and transmittal have been complied with or unless such compliance shall have been~~ COMPLIANCE WITH THE FILING AND TRANSMITTAL REQUIREMENTS MAY BE waived or dispensed with by a vote of at least two-thirds (2/3) of the delegates present at the opening session of such meeting. The Executive Director shall cause to be published in ~~The Journal~~ in advance of such meeting of the House of Delegates biographical information on all candidates meeting the requirements of filing and transmittal.

Section 4. Nomination and Election of District Councilors. Nominations for the office of District Councilor shall be made ~~from the floor of~~ AT the House of Delegates; ~~provided,~~ However, ~~that~~ only those candidates may be nominated whose names have been filed with the Executive Director ~~at the time and in the manner hereinafter~~ ~~provided, unless compliance with such requirement shall be waived as hereinafter provided;~~ that the name or names of a candidate or candidates for the office of Councilor must be filed by the caucus of that district's delegates ~~with the Executive Director of the Association prior to the opening of the first session of the House of Delegates in Annual Meeting,~~ and that no nomination for Councilor may be presented at any meeting unless the foregoing has been ~~complied with or unless such compliance shall have been~~ COMPLIANCE WITH THE FOREGOING FILING REQUIREMENT MAY BE waived or dispensed with by a vote of at least two-thirds (2/3) of the delegates present at the opening session of such meeting.

Section 5. Nomination of Officers and of Delegates and Alternate Delegates to the American Medical Association. The report of the Committee on Nominations with respect to all offices, except that of President-Elect, and with respect to all Delegates and Alternate Delegates to the American Medical Association, except for the alternate delegate elected by the Medical Student Section, shall be posted ~~at the registration desk of the Association at the earliest time practicable and at least three hours before the final session of the House of Delegates.~~ OR DISTRIBUTED PRIOR TO THE ELECTION. Nominations for the office of President-Elect ~~shall~~ MAY be made from the floor at the final session of the House of Delegates. Each nominating speech for any office shall be limited to three minutes. Not more than one speech shall be made in seconding a given nomination and such seconding speech shall be limited to one minute.

Section 6. Nominations from the Floor. Nothing in this chapter shall be construed to prevent additional nominations from the floor by delegates.

Section 7. Election of Officers and of Delegates and Alternate Delegates to the American Medical Association. IF THERE IS MORE THAN ONE NOMINEE FOR AN OFFICE, ~~the election of officers of this Association and of delegates and alternate delegates to the American Medical Association shall be by ballot. The election of delegates to the American Medical Association shall be conducted by means of a single ballot sheet and the election of alternate delegates shall likewise be conducted by means of a separate single ballot sheet.~~ Election of one alternate delegate to the American Medical Association by the OSMA Medical Student Section shall be in accordance with the bylaws of the Medical Student Section.

In the event there is only one position to be filled, the nominee receiving the majority of all votes cast shall be declared elected. In case no nominee receives a majority on the first ballot, the two nominees receiving the lowest number of votes shall be dropped and a new ballot taken; this procedure shall be continued until there are two nominees remaining. The nominee receiving a majority of all votes cast shall be declared elected.

In the event there is more than one position to be filled from among any number of nominees, a nominee, in order to be declared elected, must receive the votes of a majority of those voting, provided, however, that if upon any

838 ballot the number of nominees receiving a majority vote is greater than the number of positions to be filled on such
839 ballot, those nominees (not to exceed the number of positions to be filled on such ballot) receiving the greatest
840 number of votes shall be declared elected. If upon any ballot some but not all of such positions are filled, a new ballot
841 shall be taken from among all of the remaining nominees; except that the two nominees receiving the lowest number
842 of votes on the previous ballot shall be dropped on each new ballot until there are two more nominees than positions
843 available, after which the nominee receiving the lowest number of votes shall be dropped. On every ballot a nominee,
844 in order to be declared elected, must receive the votes of a majority of those voting, provided, however, that if upon
845 such new ballot the number of nominees receiving a majority vote is greater than the number of positions to be filled
846 on such ballot, those nominees (not to exceed the number of positions to be filled on such ballot) receiving the
847 greatest number of votes cast shall be declared elected. If upon any ballot no nominee receives the votes of a majority
848 of those voting, the two nominees receiving the lower number of votes shall be dropped and a new ballot will be
849 taken; this procedure shall be continued until there are two more nominees than positions available, after which the
850 nominee receiving the lowest number of votes shall be dropped; and this procedure shall be continued until all
851 positions have been filled. No ballot shall be counted if it contains fewer or more votes than the number of positions
852 to be filled or if the ballot purports to cast more than one vote for any nominee. (For example: if upon any ballot the
853 number of positions to be filled is four (4), then each delegate voting must vote for (4) of the nominees for such
854 positions.)
855

856 **Section 8. Removal from Office.** Any officer of this Association, or any delegate to the American Medical
857 Association, or any alternate delegate to the American Medical Association, may be removed from office, for cause,
858 at any time.
859

860 Proceedings for the removal from office of an officer of this Association or any delegate or alternate delegate to
861 the American Medical Association shall be commenced by the filing with the Executive Director of this Association
862 of a written complaint signed by not less than sixty delegates to the House of Delegates of this Association from at
863 least thirty component societies. Such complaint shall name the person sought to be removed, shall state the cause for
864 removal, and shall demand that a meeting of the House of Delegates be held for the purpose of conducting a hearing
865 on the charges set forth in the complaint, and for the purpose of selecting an individual to fill the office which may be
866 vacated by reason of the removal from office of the person sought to be removed.
867

868 Within ten (10) days after the filing of such complaint, the Executive Director shall serve upon the person named
869 in ~~such~~ THE complaint a true and correct copy of ~~such complaint~~ IT, together with a written notice specifying the
870 time and place of hearing the charges set forth in ~~such~~ THE complaint. The Executive Director shall also mail a copy
871 of ~~such~~ THE complaint and notice to each delegate to the House of Delegates of this Association. Service upon the
872 person named in ~~such~~ THE complaint of a copy of the complaint together with such written notice shall be made by
873 delivering the same personally to ~~such~~ THE person or by sending the same by certified mail addressed to ~~such~~ THE
874 person at his usual place of residence.
875

876 At the hearing upon such charges the person named in ~~such~~ THE complaint shall be afforded full opportunity to
877 be heard in his/HER own defense, to be represented by legal counsel OR ANY OTHER PERSON of his/HER own
878 choosing, to cross-examine the witnesses who testify against him/HER, and to examine witnesses and offer evidence
879 in his/HER own behalf. The House of Delegates shall convene for the purposes of hearing the charges in such
880 complaint, and electing a successor if need be:
881

882 (a) on any date during the Annual Meeting of the House of Delegates, provided the date of such Annual Meeting
883 is more than thirty (30) and less than sixty (60) days subsequent to the date of the service of such written notice upon
884 ~~such~~ THE person sought to be removed; or
885

886 (b) at a special meeting called for the purpose of hearing the charges set forth in such complaint, ~~which~~ SUCH
887 special meeting shall be held on a date more than thirty (30) and less than sixty (60) days subsequent to the date of the
888 service of ~~such~~ THE written notice upon such person sought to be removed.
889

890 A quorum FOR THE PURPOSES OF THIS SECTION shall consist of two-thirds (2/3) of the elected delegates.
891

892 If two-thirds (2/3) of the delegates of the House of Delegates present and voting by secret ballot vote
893 affirmatively to remove such person from office, such person shall be declared removed from office.
894

895 A successor to an office in which a vacancy has been created as a result of the removal from office of any such
896 officer, delegate or alternate delegate shall be elected to serve the balance of the term of such office. All nominations
897 for ~~such~~ THE office shall be made from the floor. The election of a successor officer, delegate or alternate delegate
898 shall be by a majority of the delegates present and voting and shall be in accordance with Section 5 of Chapter 5 of
899 the Bylaws of this Association, and with respect to a successor delegate or alternate delegate to the American Medical
900 Association such election shall also be in accordance with Section 5 of Chapter 4 of the Bylaws of this Association.
901
902
903

DUTIES AND TERMS OF OFFICERS AND OF THE EXECUTIVE DIRECTOR

Section 1. President. The President shall preside at all general sessions of this Association and sessions of the House of Delegates. ~~He~~ THE PRESIDENT shall appoint all committees for the selection of which other provision is not made. ~~He~~ shall deliver an annual address at a session of the House of Delegates. ~~He~~ shall be chairman of the Council and shall perform such other duties as pertain to ~~the principal administrative~~ AN officer of a corporation. ~~AND~~ ~~He~~ shall be an ex-officio member of all committees of this Association. ~~As~~ THE Immediate Past President ~~he~~ shall be a member of Council for a period of one year immediately following ~~his~~ THE term of office as President. ~~If the office of President shall become vacant, the Immediate Past President shall succeed to the Presidency and complete the unexpired term of such office; and in the event of the refusal or inability of the Immediate Past President to fill such vacancy, the President-Elect shall succeed to the Presidency and serve out the balance of such unexpired term.~~

Section 2. President-Elect. The President-Elect shall be a member of the Council and an ex-officio member of each standing committee, ~~of the Auditing and Appropriations Committee,~~ and of each ~~special or~~ other committee OR TASK FORCE appointed by the President. ~~He~~ THE PRESIDENT-ELECT shall assume the duties of the President during the temporary absence or disability of the latter. If the office of President shall ~~become~~ BE DECLARED vacant BY COUNCIL and the Immediate Past President shall refuse or be unable to fill such vacancy, the President-Elect shall serve as President during the balance of the unexpired term and thereafter during the term for which the President-Elect was elected.

Section 3. Immediate Past President. The Immediate Past President shall be a member of the Council for a period of one year immediately following ~~his~~ THE term of office as President, and during such period ~~he~~ shall be an ex-officio member of each standing committee, ~~of the Auditing and Appropriations Committee,~~ and of each ~~special or~~ other committee OR TASK FORCE appointed by the President. ~~The Immediate Past President, as well as all Past Presidents of this Association, shall have the right of the floor for discussion at all meetings of the House of Delegates.~~ IF THE OFFICE OF PRESIDENT SHALL BE DECLARED VACANT BY COUNCIL, THE IMMEDIATE PAST PRESIDENT SHALL SUCCEED TO THE PRESIDENCY AND COMPLETE THE UNEXPIRED TERM OF SUCH OFFICE.

Section 4. Secretary-Treasurer. The Secretary-Treasurer shall receive all funds due this Association from every source ~~whatever, except current accounts due The Journal in the conduct of its business.~~ ~~He~~ THE SECRETARY-TREASURER shall SUPERVISE THE deposit and keep the funds of this Association in a bank or banks of deposit approved by the Council. ~~He~~ THE SECRETARY-TREASURER shall SUPERVISE THE ACCOUNTING FOR ~~keep a complete set of books concerning~~ the receipts and expenditures of this Association, ~~except those of The Journal.~~ ~~He~~ THE SECRETARY-TREASURER shall have the duty to make such purchases, sales, leases, acquisitions or dispositions of real and personal property as may be ordered or authorized by the Council and to execute on behalf of this Association, all documents and papers which may be required in connection with any such purchases, sales, leases, acquisitions or dispositions. ~~He~~ ~~THE SECRETARY-TREASURER shall pay money out of the treasury upon vouchers as directed by the Auditing and Appropriations Committee, rendering a monthly trial balance of his accounts to each member of Council.~~ THE SECRETARY-TREASURER SHALL SUPERVISE THE PAYMENTS OF ALL BILLS OF THE ASSOCIATION AS AUTHORIZED BY THE AUDITING AND APPROPRIATIONS COMMITTEE AND/OR THE COUNCIL. At the expense of this Association ~~he~~ THE SECRETARY-TREASURER shall give bond in such amount as shall be required by the Council.

The Secretary-Treasurer shall be a member of Council and an ex-~~official~~ OFFICIO member of the Auditing and Appropriations Committee.

Section 5. Executive Director. The Executive Director shall be appointed by the Council. ~~He~~ THE EXECUTIVE DIRECTOR shall be THE ex-officio ~~he~~ secretary of the Association, of its Council, and of all its committees. ~~He~~ THE EXECUTIVE DIRECTOR shall be the executive agent of this Association and shall transact its business under the direction of its officers. ~~He~~ THE EXECUTIVE DIRECTOR shall collect, through the secretaries of the component societies, dues for membership in this Association and dues for membership in the American Medical Association and ~~he~~ shall remit to the Secretary-Treasurer of this Association all collected dues for membership in this Association and shall remit to the secretary of the American Medical Association all collected dues for membership in that association.

~~He~~ THE EXECUTIVE DIRECTOR shall be the managing editor and business manager of ANY PUBLICATION OR COMMUNICATIONS PROGRAM OF THE ASSOCIATION. ~~The Journal. He shall pay over the excess of receipts over expenses, if any, of The Journal to the Secretary-Treasurer at the end of each fiscal year, or whenever ordered to do so by the Auditing and Appropriations Committee or the House of Delegates. Whenever the income of The Journal does not meet its expenses, he shall make requisition, with the approval of the Auditing and Appropriations Committee and the Council, on the Secretary-Treasurer for the necessary funds.~~ ~~He~~ THE

EXECUTIVE DIRECTOR shall have charge of the business offices of this Association and may employ, SUPERVISE, AND DISCHARGE such aid as IS NECESSARY TO ACCOMPLISH THE PROGRAMS AUTHORIZED BY THE COUNCIL AND THE HOUSE OF DELEGATES. ~~shall be authorized by the Council. He~~ THE EXECUTIVE DIRECTOR shall be the custodian of all books and papers belonging to this Association except those of the Secretary-Treasurer.

~~He~~ THE EXECUTIVE DIRECTOR shall provide for the registration of the members at the Annual Meeting and shall provide for reporting the proceedings of the Annual Meeting. ~~He~~ THE EXECUTIVE DIRECTOR shall conduct the official correspondence, notifying members of meetings, officers of their election, committees of their appointments and duties, and ~~he~~ THE EXECUTIVE DIRECTOR shall perform such other duties as may be assigned ~~to him~~ by the President or the Council. At the expense of this Association ~~he~~ THE EXECUTIVE DIRECTOR shall give bond in such amount as shall be required by the Council.

Section 6. Terms of Officers. The President shall serve one year and shall be succeeded by the President-Elect. The term of office of the Secretary-Treasurer shall be for three years. The term of office of Councilors shall be for two years. Councilors of the odd-numbered districts shall be elected at annual meetings held in even-numbered years; and the Councilors of the even-numbered districts shall be elected in odd numbered years. All these officers shall serve until their successors are elected and qualified.

For the purposes of this section, the period from one Annual Meeting until the next shall be regarded as one year.

CHAPTER 7 THE COUNCIL

Section 1. Powers and Duties of the Council. The BOARD OF TRUSTEES (REFERRED TO HEREIN AS "THE COUNCIL") shall be the executive body of this Association. Between meetings of the House of Delegates, the Council shall have and exercise all the powers and authority conferred on the House of Delegates by the Constitution and these Bylaws. In the exercise of the interim powers thus conferred upon it, the Council shall take no action contravening any general policy which shall have been adopted by the House of Delegates and which is then in effect.

The Council shall have direction of the investment and reinvestment of the funds of this Association.

~~The Council shall determine the character and scope of the scientific proceedings of this Association and at least thirty (30) days prior to each Annual Meeting, it shall issue a program announcing the order in which papers and discussions are to be presented.~~

The Council shall ~~be the board of censors of this Association,~~ considering all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates involving the professional relations of individual physicians or groups of physicians shall be referred to the Council without discussion. The Council shall have full power and authority to REFER TO A COMMITTEE OR TASK FORCE OR hear and decide all questions of discipline affecting the conduct of the members of this Association or the conduct of a component society. Its decisions in all cases, including questions regarding the right of membership in this Association, shall be final.

The Council shall provide for and superintend the issuance of ANY PUBLICATIONS OF ~~the Ohio State Medical Journal~~ ASSOCIATION. ~~referred to herein otherwise as The Journal.~~ It shall have full power and authority to appoint a medical editor or publication board, or both, and make any other provisions for the publication of ~~The Journal~~ ANY PUBLICATIONS which in its judgment are feasible including full discretionary power: (1) to promulgate rules and regulations governing ~~the ANY publications of The Journal;~~ (2) to enumerate and define the powers and duties of the medical editor or publication board, or both; and (3) to fix the terms and conditions of their appointment.

The Council shall have full power and authority to employ an Executive Director, who need not be a physician or member of this Association, ~~and to employ such other employees as the Council may deem necessary or advisable.~~ THE EXECUTIVE DIRECTOR MAY EMPLOY SUCH OTHER EMPLOYEES AS ARE DEEMED NECESSARY OR ADVISABLE.

The Council shall provide such offices for the headquarters of this Association as may be required properly to conduct its business.

Section 2. Council Meetings. The Council shall hold meetings during the Annual Meeting of this Association and at such other times as ~~necessity may require~~ NECESSARY, subject to the call of the President or on the petition of three Councilors filed with the Executive Director.

Section 3. Publication of Proceedings. The Council shall cause to be published ~~in The Journal of this Association~~ a summary of its meetings and actions.

Section 4. Individual Duties of Councilors. Each Councilor shall be the organizer, peacemaker and censor for his district. He shall visit each county in his THAT COUNCILOR'S district at least once each year for the purposes of inquiring into the condition of the profession and of each component society in his THAT district and of keeping in touch with the activities of each of such societies. In every disciplinary matter involving a member of a component society located in the Councilor's district, the Councilor, in advance of a hearing on any charges filed against such member, shall make every effort to effect a conciliation or compromise consistent with honor and the principles of medical ethics.

The duties of the ~~non-voting~~ Councilor from the Hospital Medical Staff Section shall be set forth in the bylaws of said section. The duties of the ~~non-voting~~ Councilor from the Medical Student Section shall be set forth in the Bylaws of said section. The duties of the Councilor from the Resident Physician's Section shall be set forth in the Bylaws of said section which shall be approved by the Council.

Section 5. Auditing and Appropriations Committee. An Auditing and Appropriations Committee consisting of three members of the Council shall be appointed by the President, with the consent of the Council, to serve for one year. This Committee shall prescribe the method of accounting and shall audit any and all accounts of this Association. It shall prepare and present annually to the Council a budget providing for the necessary expenses of this Association. The budget, after approval by the Council, shall be published and distributed to the delegates and alternate delegates at least 90 days prior to the Annual Meeting. Any surplus or balance of funds for a given year shall revert to the general fund. The President, the President-Elect, the Immediate Past President and the Secretary-Treasurer shall be ex-officio members of such Committee with full voting rights.

Section 6. Salaries and Expenses of Officers and Employees THE BUDGET. The salaries of officers and employees THE BUDGET of this Association shall be fixed by the Council. The Auditing and Appropriations Committee may allow the payment of necessary traveling and other expenses incurred by officers and Councilors in the discharge of their duties to this Association.

Section 7. Vacancies. Except as otherwise provided by Chapter 6 hereof, the Council shall fill by appointment any vacancy in office occurring in the interval between the Annual Meetings of the House of Delegates. Any such appointee shall serve until the next Annual Meeting of the House of Delegates at which time the office shall be filled in the manner provided for in the Constitution and in these Bylaws.

CHAPTER 8 DELEGATES AND ALTERNATE DELEGATES TO THE ~~AMA~~ AMERICAN MEDICAL ASSOCIATION

Section 1. Organization. As soon as practicable after their election and installation, the Delegates and Alternate Delegates to the American Medical Association shall nominate from their membership candidates for the ~~chairmanship~~ CHAIR and ~~vice chairmanship~~ VICE-CHAIR of the delegation and the Council of this Association shall elect one of such nominees as ~~Chairman~~ CHAIR and one as ~~Vice Chairman~~ VICE-CHAIR. The President of this Association will be ex-officio ~~Co-Chairman~~ CO-CHAIR of the delegation.

Section 2. Duties of the ~~Chairman~~ CHAIR. He THE CHAIR shall act as ~~Co-Chairman~~ CO-CHAIR with the President of this Association of meetings of the delegation. He THE CHAIR shall appoint such committees as may be necessary to assist the work of the delegation. He THE CHAIR shall report periodically for the delegation to the Council of this Association.

Section 3. Duties of the ~~Vice-Chairman~~ VICE-CHAIR. He THE VICE-CHAIR shall perform the duties of the ~~Chairman~~ CHAIR when the ~~Chairman~~ CHAIR is absent or otherwise unable to function.

SECTION 4. DUTIES OF AMERICAN MEDICAL ASSOCIATION DELEGATION MEMBERS. MEMBERS OF THE OHIO DELEGATION TO THE AMERICAN MEDICAL ASSOCIATION ARE EXPECTED TO ATTEND ALL SESSIONS OF THE AMA HOUSE OF DELEGATES AND ALL OHIO AMA DELEGATION FUNCTIONS. MEMBERS OF THE OHIO DELEGATION TO THE AMA MUST PREPARE FOR EACH AMA HOUSE OF DELEGATES MEETING BY REVIEWING MATERIALS SENT TO THEM AND PARTICIPATE IN THE DELIBERATIONS OF VARIOUS COMMITTEES TO WHICH THEY MAY BE ASSIGNED. MEMBERS OF THE OHIO DELEGATION TO THE AMA SHALL PARTICIPATE IN MEMBERSHIP PROMOTION ACTIVITIES IN THEIR LOCAL SOCIETIES AND DISTRICTS FOR BOTH THE OSMA AND THE AMA.

Section 45. Terms of Office. The ~~Chairman~~ CHAIR and ~~Vice-Chairman~~ VICE-CHAIR shall serve for a period of one year or until their successors are duly elected and qualified.

Section 56. Terms of Office for Medical Student Section Alternate Delegate. The Alternate Delegate elected by the Medical Student Section shall serve for a period of one year from the time of election. This Alternate Delegate shall be eligible for reelection so long as medical student status is maintained.

CHAPTER 9 COMMITTEES

Section 1. ~~Titles of Committees.~~ The standing Committees of this Association shall be THE COMMITTEE ON AUDITING AND APPROPRIATIONS AND THE COMMITTEE ON JUDICIAL AND PROFESSIONAL RELATIONS. ALL OTHER COMMITTEES AND TASK FORCES OF THIS ASSOCIATION SHALL BE ~~the following:~~

~~1. Committee on Communications, 2. Committee on Accreditation, 3. Committee on Education, 4. Committee on Judicial and Professional Relations, 5. Committee on Membership, and 6. Committee on Art and Culture.~~

~~Other committees of this Association shall be those designated in Section 4 and 7 of Chapter 4; Section 1 of Chapter 5 and Section 5 of Chapter 7, and such special committees as may be appointed by the pPresident.~~

Section 2. Appointment. The President with approval of Council shall appoint the ~~chairman~~ CHAIR and members of each ~~standing and special committee; AND TASK FORCE.~~ Each committee chairman shall serve a one year term, and may serve a maximum of three consecutive one year appointments. A committee chairman who has served three one year appointments is eligible for reappointment as chairman after one year. The limitations on years of service as chairman shall not affect the member's right to be appointed to serve on any committee.

~~Each committee member shall be appointed for a two year term, except for the first appointments at which time one half of the committee shall be appointed for one year and one half of the committee shall be appointed for two years. Each committee member is limited to three consecutive two year terms on any one committee. A member having served the maximum of three consecutive two year terms is eligible for reappointment to such committee after one year. A member may serve on more than one committee simultaneously. If a vacancy occurs in any committee, the President with approval of Council, may fill the vacancy for the remainder of the term.~~

Section 3. Duties and Responsibilities of Committees-AND TASK FORCES. Each ~~standing and special~~ committee AND TASK FORCE shall consider all items referred thereto by the House of Delegates and the Council. The purpose(s) of each committee AND TASK FORCE shall be prescribed by the Council.

The actions of all ~~standing and special~~ committees AND TASK FORCES shall be subject to the approval of the Council.

CHAPTER 10 COMPONENT SOCIETIES

Section 1. Organization of Societies. Upon application to the House of Delegates, all component societies hereafter organized in this state, which have adopted principles of organization in conformity with the Constitution and Bylaws of this Association, shall receive charters from this Association; provided, however, that their constitutions and bylaws or, ~~in the case of incorporated societies,~~ their articles of incorporation, codes of regulations, codes of bylaws or other fundamental bodies of rules of society government, shall have been submitted to the Council and received its approval. All such charters shall be signed by the President and the Secretary-Treasurer.

Section 2. Suspension or Revocation of Charters of Societies. The House of Delegates shall have authority and power to suspend or revoke a charter heretofore or hereafter issued to any component society whose actions are in conflict with the Constitution or Bylaws of this Association.

Section 3. Title of a Component Society. The name and title of each component society shall read exactly as found in its charter. No change in such name shall be made without the approval of the Council of this Association.

Section 4. Custody of Charter. The charter of each component society, as issued by this Association, shall be preserved and shall be kept in the custody of the secretary of such component society at all times.

Section 5. Constitutions of Component Societies. Each unincorporated component society shall have a constitution and bylaws. Each incorporated component society shall have, in addition to articles of incorporation as required by law, a constitution, a code of regulations, a code of bylaws, or other fundamental body of rules for its government similar in content and form to the bylaws of unincorporated component societies. All such constitutions, bylaws, articles of incorporation, codes of regulations and other fundamental bodies of rules AND ALL OTHER RULES AND REGULATIONS ADOPTED BY A COMPONENT SOCIETY shall be in conformity to the Constitution and Bylaws of this Association, and a copy thereof shall be transmitted to the headquarters of this Association for approval and recording. The bylaws of each unincorporated component society, and the code of regulations, code of bylaws, or other fundamental body of rules of each incorporated society shall set forth specifically the duties of the several officers and of its executive body (council or trustees).

1168 **Section 6. RULES, REGULATIONS AND Changes In Constitution and Bylaws of Component Societies.**

1169 Whenever a component society ~~shall have made~~ MAKES a change or amendment in its constitution, bylaws, articles
1170 of incorporation, code of regulations, or other fundamental body of rules for its government, OR ADOPTS ANY
1171 RULES OR REGULATIONS, such change, ~~or amendment,~~ RULE OR REGULATION shall be submitted to the
1172 Council of this Association for written approval, and ~~such change or amendment~~ shall not become effective until such
1173 approval ~~shall have~~ HAS been given.

1174
1175 **Section 7. Functions and Duties of Component Societies.** Each component society shall have general
1176 direction of the business and affairs of the profession in the county, and it shall exert its influence to promote the
1177 science and art of medicine, the moral condition of the membership, and the betterment of public health.

1178
1179 **Section 8. Date Membership Dues are Payable.** The membership dues in all component societies shall be due
1180 and payable on or before December 1 preceding the calendar year for which such dues are assessed.

1181
1182 **Section 9. Official Records of Component Societies.** The official copy of the constitution and bylaws of each
1183 unincorporated component society, and the official copy of the articles of incorporation, code of regulations, code of
1184 bylaws or other fundamental body of rules of each incorporated component society, shall be kept by such component
1185 society in a special book provided for that purpose. ~~In such special book shall be entered All amendments which have~~
1186 ~~been approved by the Council of this Association SHALL BE ENTERED IN A SPECIAL BOOK. Such book shall~~
1187 ~~contain the name and address of each component society member who is entitled to membership in this Association;~~
1188 ~~and there shall be recorded in it the date of each member's election, the date of his decease and the date of any~~
1189 ~~resignation or order of suspension or expulsion from the society. It shall be the duty of the society's secretary to~~
1190 ~~preserve this book and hold it available when required for reference.~~

1191
1192 **Section 10. Certification of Delegates of Component Societies.** Each component society at its regular annual
1193 meeting shall elect delegates to represent it in the House of Delegates of this Association in accordance with these
1194 Bylaws, unless other definite procedure for the selection of delegates is provided in its constitution and bylaws, or in
1195 its articles of incorporation, code of regulations, code of bylaws, or other fundamental body of rules of society
1196 government. The secretary of each component society shall send a list of such delegates and alternates to the
1197 Executive Director of this Association at least ~~thirty (30)~~ SIXTY (60) days before the Annual Meeting of this
1198 Association. Representation in the House of Delegates shall be contingent on compliance with the foregoing
1199 provisions. In the absence of, or the disability or disqualification of a delegate, ~~his~~ THE DELEGATE'S duly certified
1200 alternate shall be seated in ~~his~~ THE DELEGATE'S place.

1201
1202 **Section 11. Combined Component Societies.** The House of Delegates shall have authority to organize the
1203 physicians of two or more counties, or parts thereof, into a multi-county society to be designated by hyphenating the
1204 names of such counties so as to distinguish them from a district or single county society. Such multi-county societies,
1205 when organized and chartered, shall be entitled to all the privileges and representatives provided herein for component
1206 societies.

1207
1208 **CHAPTER 11**
1209 **MEMBERSHIP IN COMPONENT SOCIETIES**
1210

1211 **Section 1. Qualifications for Membership In a Component Society.** To be eligible for active membership,
1212 associate membership or in-training membership in a component society, or other probationary or provisional type of
1213 membership of limited duration, a person must possess all of the following qualifications:

1214
1215 (a) ~~He~~ A PERSON must meet all those requirements for membership in this Association which are enumerated
1216 in Section 3 of Chapter I, hereof, and at the time of making application to the component society shall tender the
1217 appropriate Ohio State Medical Association dues and assessments for the current year;

1218
1219 (b) ~~He~~ A PERSON must be a bona fide resident of, or must conduct the major portion of his/HER practice in,
1220 the county in which such component society is located.

1221
1222 ~~Provided, however, that where it is more convenient for a member of a component society to attend the meetings~~
1223 ~~of another component society located in a county adjoining that in which he THE MEMBER holds such membership,~~
1224 ~~such member, upon application to, and approval by, both the society in which he THE MEMBER holds such~~
1225 ~~membership and the society in such adjoining county, shall be entitled to a transfer of his THE membership to the~~
1226 ~~latter society; and, provided further, that. No A person possessing an active membership, associate, membership, or~~
1227 ~~in-training, membership, or probationary, or provisional type of membership of limited duration, in one component~~
1228 ~~society may acquire or possess at the same time an active membership, or an associate, or probationary or provisional~~
1229 ~~type of membership of limited duration, in another component society, BUT MAY BE COUNTED FOR PURPOSES~~
1230 ~~OF REPRESENTATION IN THE OSMA HOUSE IN ONLY ONE COMPONENT SOCIETY.~~

1231
1232 As used in this Section I, "active membership" in a component society means any type of membership having
1233 voting and office-holding rights and privileges.

1234 Subject to the provisions of the foregoing paragraphs of ~~this~~ Section 1, each component society shall be the sole
1235 judge of the qualifications necessary for any and all classes of membership in such society.
1236

1237 **Section 2. Roster of Members.** The secretary of each component society shall keep a roster of its members, in
1238 which shall be shown the full name, address, college AND MEDICAL OR OSTEOPATHIC SCHOOL and dateS of
1239 graduation, date of license to practice in this state, and such other information as may be deemed necessary by
1240 Council.
1241

1242 **Section 3. Change of Residence.** When a member in good standing in a component society moves to another
1243 county in this state, ~~he~~ THE MEMBER shall be given upon request a written certificate of those facts by the secretary
1244 of ~~his~~ THE society, without cost, for transmittal to the secretary of the component society in the county to which ~~he~~
1245 THE MEMBER moves. Pending ~~his~~ acceptance or rejection by the society in the county to which ~~he~~ THE MEMBER
1246 moves, such member shall be considered to be in good standing in the component society from which ~~he~~ THE
1247 MEMBER was certified and in this Association to the end of the period for which ~~his~~ THE MEMBER'S dues have
1248 been paid.
1249

1250 **Section 4. Disciplinary Procedure.** Disciplinary action may be taken by a component society against a
1251 member thereof only upon written charges signed by ~~a member or~~ members of such society and filed with the
1252 society's secretary. IF AFTER REVIEWING THE COMPLAINT, THE COMPONENT SOCIETY DETERMINES
1253 THAT DISCIPLINARY ACTION IS ADVISABLE, THE SECRETARY OF THE SOCIETY SHALL PROMPTLY
1254 GIVE NOTICE OF THE PROPOSED ACTION TO THE MEMBER, INCLUDING THE RIGHT OF THE
1255 MEMBER TO REQUEST A HEARING WITHIN THIRTY (30) DAYS OF THE DATE OF NOTICE, AND A
1256 SUMMARY OF THE RIGHTS AND PROCEDURES TO BE FOLLOWED IN A HEARING. A COPY OF THE
1257 NOTICE SHALL ALSO BE FURNISHED TO THE DISTRICT COUNCILOR. ~~As soon as possible, and in any~~
1258 ~~event not later than ten (10) days after such filing, the secretary shall serve upon the accused member a true copy of~~
1259 ~~such charges and shall also furnish to the Councilor for the district a copy thereof. Within thirty (30) days thereafter,~~
1260 ~~the society shall fix a time and place for a hearing on said charges and the secretary shall serve prompt written notice~~
1261 ~~of such time and place upon the accused member and shall also furnish to the Councilor for the district a copy of such~~
1262 ~~notice. Such hearing shall be held as soon as practicable but in no event sooner than twenty (20) UPON RECEIPT OF~~
1263 ~~A REQUEST FOR HEARING, A HEARING SHALL BE SCHEDULED TO COMMENCE NOT LESS THAN~~
1264 ~~THIRTY (30) days, or later than sixty (60) NINETY (90) days, after the date of service of such notice upon the~~
1265 ~~accused member. RECEIPT OF THE REQUEST FOR HEARING. Service upon the accused of a copy of such~~
1266 ~~charges or of such written notice, or both, may be made by delivering the same personally to the accused, or by~~
1267 ~~sending the same by registered mail and also by regular mail addressed to the accused at his THE ACCUSED'S usual~~
1268 ~~place of residence.~~
1269

1270 At the hearing upon such charges the accused shall be afforded full opportunity to be heard in his/HER own
1271 defense, to be represented by legal counsel OR ANY OTHER PERSON of his/HER own choosing. THE ACCUSED,
1272 LEGAL COUNSEL OR OTHER REPRESENTATIVE OF THE ACCUSED SHALL HAVE THE RIGHT to cross-
1273 examine the witnesses who testify against ~~him~~ THE ACCUSED, and to examine witnesses and offer evidence in
1274 his/HER own behalf. The hearing shall be held and conducted in such a manner as to ascertain all the facts fairly to
1275 the accused and the society without requiring compliance with those formal or technical rules and requirements which
1276 ordinarily pertain to judicial proceedings. Failure of the accused to appear or be represented at the hearing may be
1277 considered prima facie evidence of the truth of the charges.
1278

1279 A record shall be made of such hearing, and at the request of either the accused member or the component
1280 society, the society's secretary shall cause a transcript to be made of the proceedings, evidence and findings in
1281 connection with such hearing ~~without charge to the accused member.~~ UPON PAYMENT OF ANY REASONABLE
1282 CHARGES ASSOCIATED WITH THE PREPARATION THEREOF. If the findings shall include, or be followed
1283 by, an order or decree of the component society suspending or expelling the accused member from the society, the
1284 execution or enforcement of such order or decree shall be stayed until ~~the expiration of~~ 30 DAYS FOLLOWING the
1285 time allowed ~~by Section 5 hereof~~ for the perfecting of an appeal to the OSMA, and thereafter shall be stayed during
1286 the pendency of any appeal that may have been timely ~~filed~~ REQUESTED and ~~perfected~~ ACCEPTED. Prompt
1287 written notice of the findings and order or decree shall be served by the secretary upon the accused member together
1288 with a copy of such findings and order or decree.
1289

1290 **Section 5. Appeals.** Any member who has been censured by his/HER component society, or who has been
1291 suspended or expelled from membership therein, shall have the right to REQUEST AN appeal to the Council of this
1292 Association from the order of censure, suspension or expulsion; ~~and the Council shall have~~ MAY, IN ITS OWN
1293 DISCRETION, EXERCISE ITS jurisdiction to hear and determine such appeal, and to affirm, modify or reverse the
1294 order of the component society; OR TO REMAND THE MATTER TO THE COMPONENT SOCIETY FOR
1295 FURTHER CONSIDERATION. Any such appeal shall be on questions of law and procedure only, and not on
1296 questions of fact. ~~Such~~ THE REQUEST FOR appeal must be filed with the Council within ~~twenty (20)~~ 60 days after
1297 the date of the service upon the accused member of the component society's order from which the appeal is
1298 ~~taken~~ SOUGHT. With such REQUEST FOR appeal the appellant shall file proof that a copy of ~~such~~ THE
1299 REQUEST FOR appeal has been mailed to, or otherwise served upon, the president or secretary of the component

society from whose order the appeal is ~~taken~~ SOUGHT.

WITHIN 45 DAYS AFTER THE RECEIPT OF A REQUEST FOR APPEAL, COUNCIL SHALL DETERMINE WHETHER OR NOT IT WILL EXERCISE ITS JURISDICTION TO HEAR THE APPEAL, AND NOTIFY THE MEMBER AND THE COMPONENT SOCIETY OF THAT DETERMINATION.

As soon as practicable, and IF COUNCIL CHOOSES TO HEAR THE APPEAL within ~~forty (40)~~ SIXTY (60) days after the filing of such appeal, or within such additional time as may be allowed by the Council, the component society shall file with the Council a record of the society's disciplinary proceedings against the appellant, including the original papers, documents, resolutions and minutes, or copies thereof, relating ~~thereto~~ TO THE ACTION, and including a transcript of the proceedings, evidence and findings in connection with its hearing on the charges against the appellant. With such record there shall be filed a certificate signed by the president or secretary of such society certifying that such record constitutes a complete, true and correct record of all the disciplinary proceedings before such society, and further certifying that a true and correct copy of such record, and written notice of the filing of such record with the Council, have been mailed to, or otherwise served upon, the appellant. If the component society ~~shall~~ failS or refuseS to file such record within the said ~~forty (40)~~ SIXTY (60) days or within such additional time as may be allowed by the Council, the Council may enter an order sustaining such appeal and reversing the order or decree of the component society.

Following the filing of the record by the society the Council shall fix the time for the filing of briefs by the ~~accused~~ APPELLANT and the society and shall set a date for the hearing of the appeal before the Council, and the Executive Director shall give prompt notice thereof to each party and to each party's legal counsel.

The appeal shall be heard, considered and determined by the Council solely upon the record filed by the society with the Council and upon the briefs and oral arguments of the parties or their legal counsels, ~~and~~ ~~The~~ The decision of the Council shall be final and binding on both the accused member and the society.

~~**Section 6. Effect of Failure of a Component Society to take Requested Disciplinary Action.** In the event that a component society shall fail or refuse to take prompt disciplinary action against one of its members after being requested in writing by the Council of this Association to do so, the Council of this Association may cause such disciplinary action to be instituted and prosecuted; and in any such disciplinary action so instituted the procedure prescribed by Section 6 of Chapter 1 of these Bylaws shall govern; and at the conclusion of the hearing by the Council it may enter such order of (a) dismissal of the charges, or (b) censure of the accused member, or (c) suspension from the society, or (d) expulsion from the society as the evidence adduced at such hearing shall warrant. The accused member may appeal the decision of the Council on questions of law and procedure, but not of fact, to the Judicial Council of the AMA by filing a notice of appeal with the Judicial Council within thirty days of the decision of Council, such appeal to be governed by the rules and regulations of the Judicial Council. The decision of Council shall be final pending an appeal to the Judicial Council.~~

Section 76. Limitation of Liability. No member or employee serving on a utilization committee, a peer review or professional standards review committee, which includes participation in the context of this disciplinary Chapter, of the Association shall be deemed liable in damages to any person for any action taken or recommendation made within the scope of the functions of said committee, if such committee member or employee acts without malice and in the reasonable belief that such action or recommendation is warranted by the facts known to ~~him~~ SUCH PERSON after reasonable effort to obtain the facts of the matter as to which such action is taken or recommendation is made. NO PERSON AGAINST WHOM DISCIPLINARY ACTION IS INSTITUTED PURSUANT TO THE DISCIPLINARY CHAPTER OF THESE BYLAWS SHALL HAVE ANY CLAIM OR CAUSE OF ACTION AGAINST THIS ASSOCIATION, OR AGAINST ANY OFFICER, COUNCILOR, MEMBER, AGENT OR EMPLOYEE OF THIS ASSOCIATION, BY REASON OF THE INSTITUTION, PROSECUTION, OR DISPOSITION OF SUCH CHARGES OR THE HEARING OR CONSIDERATION THEREOF.

Section 86. Effect of Expiration, Revocation or Termination of a Certificate. Membership in a component society of a member of such society whose certificate to practice medicine and surgery, or osteopathic medicine and surgery, has expired, has been revoked or has been otherwise terminated, shall be cancelled automatically as of the effective date of such expiration, revocation, or termination. The provisions of this Section 8 shall not apply to members who have retired from active practice.

Section 97. Effect of Failure to Maintain Membership In the Ohio State Medical Association. Membership in a component society of a member of such society who has failed to acquire and maintain membership in this Association shall terminate automatically.

CHAPTER 12 ETHICAL PRINCIPLES

The ethical principles governing the members of the American Medical Association shall govern members of this Association.

**CHAPTER 13
RULES OF PROCEDURE**

The deliberations of this Association shall be conducted in accordance with parliamentary usage as prescribed in the current edition of Sturgis' Standard Code of Parliamentary Procedure, by Alice Sturgis.

**CHAPTER 14
REFERENDUM**

Within sixty (60) days after a general referendum has been ordered either by the (1) House of Delegates, or (2) upon the petition of the presidents of at least twenty-three (23) component societies as prescribed in Article X of the Constitution, the Executive Director shall prepare and have printed and mailed by first-class mail to each Active Member of this Association an official circular setting forth the following:

- (a) A resume of the provisions in this Constitution and Bylaws applying to a general referendum;
- (b) An announcement by the President as to the time set ~~by him~~ for closing the polls which shall be not less than fifteen (15) days or more than thirty (30) days after the mailing of circulars and ballots;
- (c) The resolution, motion or action submitted to referendum;
- (d) A statement of not more than 200 words prepared by the proposer or proposers of the resolution, motion or action giving arguments in its favor;
- (e) A statement of not more than 200 words giving arguments in opposition prepared by one or more members appointed by the President from among those opposed to the resolution, motion or action.

Enclosed with the circular shall be an official reply envelope and a ballot labeled with the official seal of this Association. On the ballot the resolution, motion or action shall be printed and below it shall be spaces for the indication of "yes" or "no" by making a cross mark. The reply envelope shall be addressed to a special committee of three tellers appointed by the President and it shall carry return first-class postage or the equivalent thereof under the postal regulations.

To be counted by the tellers a ballot shall meet the following requirements:

- (a) Either "yes" or "no" must be clearly indicated with a cross mark;
- (b) The ballot must be received by the committee of tellers in the sealed official reply envelope by first-class postage on or before the day set for closing the polls; and
- (c) The ballot must be an official ballot mailed to each Active Member, duly labeled with the seal of this Association.

Within ten days following the time set for closing the polls, the tellers shall meet at the headquarters office of this Association to open the envelopes containing the ballots and poll the votes in the presence of each other, keeping in mind that the referendum is not valid unless participated in by not less than one-half of the Active Members of this Association.

The results of the referendum shall be transmitted in writing by the tellers to the President immediately after the count has been completed. The President shall announce such results to the members of the Council and publication thereof shall be made. ~~in The Journal of this Association.~~ TO THE ACTIVE MEMBERS.

Except as otherwise provided in Article X of the Constitution of this Association, a resolution, motion or action receiving a majority of the votes cast in a valid referendum, shall be declared adopted, carried or ratified, as the case may be, and the same shall become effective fifteen (15) days after the results of the referendum ~~shall~~ have been published. ~~in The Journal.~~

**CHAPTER 15
INDEMNIFICATION**

SECTION 1. INDEMNIFICATION. IN THE EVENT THAT ANY PERSON WHO WAS OR IS A PARTY OR IS THREATENED TO BE MADE A PARTY TO ANY THREATENED, PENDING OR COMPLETED ACTION, SUIT OR PROCEEDING, WHETHER CIVIL, CRIMINAL, ADMINISTRATIVE OR INVESTIGATIVE, SEEKS INDEMNIFICATION FROM THE ASSOCIATION AGAINST EXPENSES (INCLUDING ATTORNEY FEES), AND IN THE CASE OF ACTIONS OTHER THAN THOSE BY OR IN THE RIGHT OF THE ASSOCIATION, JUDGMENTS, FINES AND AMOUNTS PAID IN SETTLEMENT, INCURRED BY HIM OR

HER IN CONNECTION WITH SUCH ACTION, SUIT OR PROCEEDING BY REASON OF THE FACT THAT SUCH PERSON IS OR WAS A MEMBER OF THE COUNCIL, AN OFFICER, OR A MEMBER OF ANY COMMITTEE OR COMMISSION OF THE ASSOCIATION, OR IS OR WAS SERVING AT THE REQUEST OF THE ASSOCIATION AS A TRUSTEE, DIRECTOR, OFFICER, EMPLOYEE, AGENT OR A MEMBER OF A COMMITTEE OR COMMISSION OF ANOTHER CORPORATION (DOMESTIC OR FOREIGN, NONPROFIT OR FOR PROFIT), PARTNERSHIP, JOINT VENTURE, TRUST OR OTHER ENTERPRISE, THEN, UNLESS SUCH INDEMNIFICATION IS ORDERED BY A COURT, THE ASSOCIATION SHALL DETERMINE OR CAUSE TO BE DETERMINED IN THE MANNER PROVIDED IN SECTION 1702.12(E)(4) OF THE REVISED CODE OF OHIO WHETHER OR NOT INDEMNIFICATION IS PROPER IN THE CIRCUMSTANCES BECAUSE THE PERSON CLAIMING SUCH INDEMNIFICATION HAS MET THE APPLICABLE STANDARDS OF CONDUCT SET FORTH IN DIVISIONS (E)(1) AND (E)(2) OF SECTION 1702.12 OF THE REVISED CODE OF OHIO AND, TO THE EXTENT THAT IT IS SO DETERMINED THAT SUCH INDEMNIFICATION IS PROPER, THE PERSON CLAIMING INDEMNIFICATION SHALL BE INDEMNIFIED.

SECTION 2. ADVANCEMENT OF EXPENSES. EXPENSES, INCLUDING ATTORNEY'S FEES, INCURRED IN DEFENDING ANY ACTION, SUIT, OR PROCEEDING REFERRED TO IN SECTION 1 OF THIS ARTICLE MAY BE PAID BY THE ASSOCIATION IN ADVANCE OF THE FINAL DISPOSITION OF SUCH ACTION, SUIT, OR PROCEEDING AS AUTHORIZED BY THE COUNCIL IN THE SPECIFIC CASE UPON RECEIPT OF AN UNDERTAKING BY OR ON BEHALF OF THE PERSON REIMBURSED TO REPAY SUCH AMOUNT UNLESS IT SHALL ULTIMATELY BE DETERMINED THAT HE OR SHE IS ENTITLED TO BE INDEMNIFIED BY THE ASSOCIATION AS AUTHORIZED IN THIS ARTICLE.

SECTION 3. NON-EXCLUSIVITY OF THIS ARTICLE. THE INDEMNIFICATION PROVIDED BY SECTION 1 OF THIS ARTICLE SHALL NOT BE DEEMED EXCLUSIVE OF ANY OTHER RIGHTS TO WHICH THOSE SEEKING INDEMNIFICATION MAY BE ENTITLED UNDER THE LAW OR ANY AGREEMENT, VOTE OF DISINTERESTED MEMBERS OF THE COUNCIL OR OTHERWISE, BOTH AS TO ACTION IN HIS OR HER OFFICIAL CAPACITY AND AS TO ACTION IN ANOTHER CAPACITY WHILE HOLDING SUCH OFFICE, AND SHALL CONTINUE AS TO A PERSON WHO HAS CEASED TO HOLD SUCH OFFICE AND SHALL INURE TO THE BENEFIT OF THE HEIRS, EXECUTORS, AND ADMINISTRATORS OF SUCH A PERSON.

SECTION 4. INSURANCE. THE ASSOCIATION, TO THE EXTENT PERMITTED BY CHAPTER 1702 OF THE OHIO REVISED CODE, MAY PURCHASE AND MAINTAIN INSURANCE ON BEHALF OF ANY PERSON DESCRIBED IN THIS ARTICLE.

CHAPTER 156 AMENDMENTS

Section 1. Method of Amending. These Bylaws may be amended at any Annual Meeting of the House of Delegates by a majority vote of the delegates present at that session, provided that the proposed amendment shall have been published TO THE ACTIVE MEMBERS ~~in The Journal~~ or mailed to ~~all~~ ACTIVE Members of the Association at least thirty (30) days prior to the Annual Meeting.

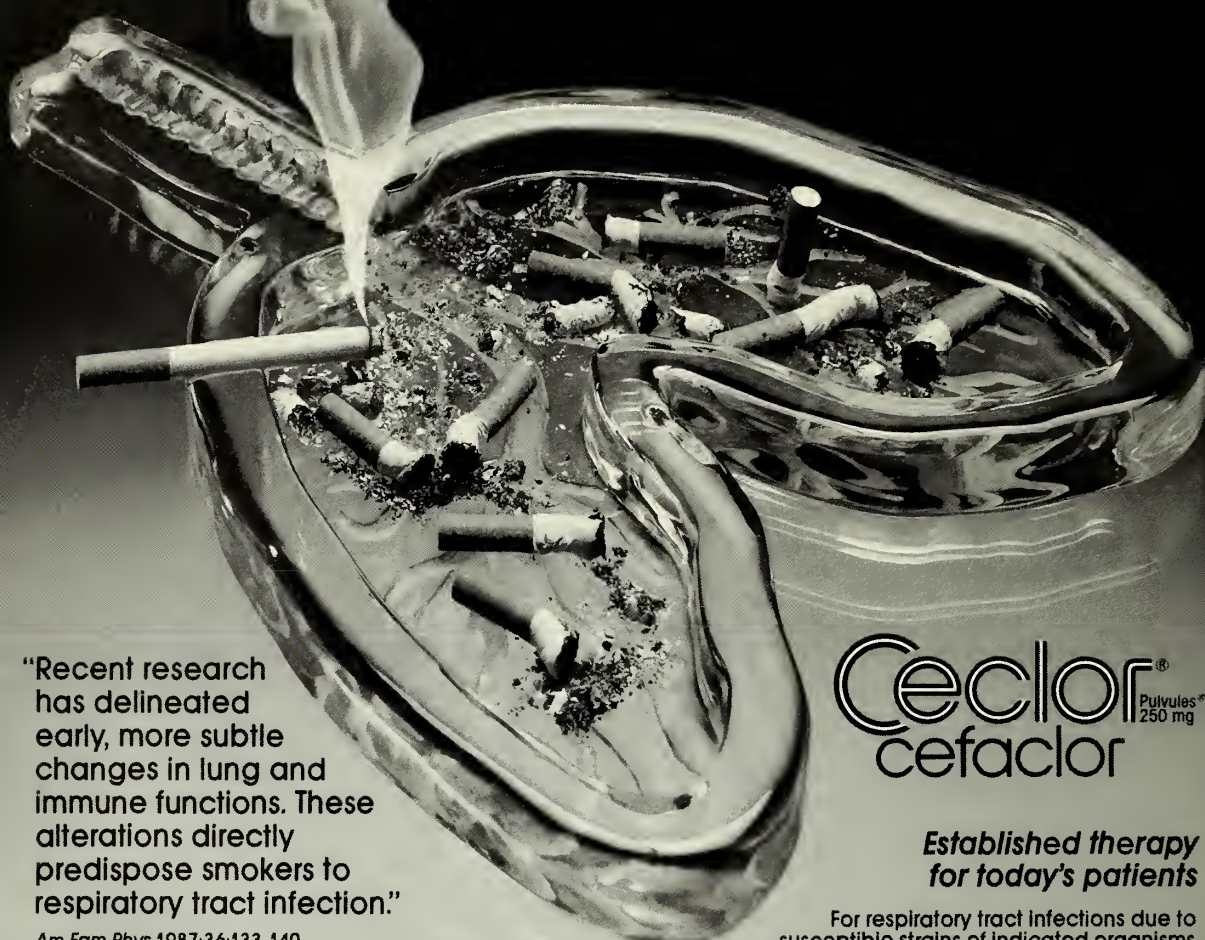
Section 2. Conformity by Component Societies. When an amendment of these Bylaws has been adopted as provided in Section 1 hereof, it shall be the duty of the Executive Director to notify the secretary of each component society within sixty (60) days after such amendment has become effective. It shall become incumbent upon each component society to make such changes in its constitution and bylaws, or, if the society be a corporation, in its articles of incorporation, code of regulations, code of bylaws, or other fundamental body of rules for the government of the corporation, as will bring about conformity to the change in the Bylaws of this Association.

Within one hundred and eighty (180) days after such notification to each component society, written notice of compliance by such component society with provision, together with copies of the changes made to effect such compliance, shall be sent by the secretary of such component society to the Council for its review and approval.

CHAPTER 167

Upon the adoption of these Bylaws, all previous Bylaws are hereby declared null, void and of no effect.

Where there's smoke...there may be bronchitis



"Recent research has delineated early, more subtle changes in lung and immune functions. These alterations directly predispose smokers to respiratory tract infection."

Am Fam Phys 1987;36:133-140

Ceclor[®]
Pulvules[®]
250 mg
cefactor

**Established therapy
for today's patients**

For respiratory tract infections due to susceptible strains of indicated organisms

Brief Summary.

Consult the package literature for prescribing information. Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of non-susceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, serum-sickness-like reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
- Stevens-Johnson syndrome, toxic epidermal necrolysis,

and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.

- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology:

- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and ClinTest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

PA 8791 AMP

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Lilly

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630
A Subsidiary of Eli Lilly and Company
Indianapolis, Indiana 46285

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The FDA's New Drug Rating System

Editor's note: *This article was sent to us by William Rogers, MD, a member of OHIO Medicine's Advisory Board. Although it appeared in the newsletter "Farmacy Phacts," published by the Children's Hospital Medical Center of Akron, the original source is the University of Pittsburgh Medical Center's University Medicine.*



The FDA rating system was originally intended to be used only by Bureau of Drugs personnel for administrative purposes

and for prioritizing new drug products. In recent years, however, the ratings for newly approved drugs have been widely circulated in the medical literature and lay press. As a consequence, health-care personnel must anticipate inquiries from patients and family members regarding highly rated new drugs. The FDA's Bureau of

Drugs uses a classification system that categorizes new drug products according to chemical type and therapeutic potential. An initial rating based on the manufacturer's research data is assigned by FDA reviewers at an early stage in the development of the product, and a final classification based on the FDA's results is assigned at the time the drug is approved for marketing.

Each drug is rated with a number-letter designation. The number portion indicates the newness or uniqueness of the drug molecule. A number is assigned from a scale of one through six; in general, the lower the number designation, the more novel the product.

- new molecular entity not previously marketed in the United States — 1
- new salt, ester or derivative of a previously approved compound — 2
- new formulation or dosage of a previously approved compound — 3
- new combination product of two or more previously approved drugs — 4
- exact duplicate of a drug already manufactured by another firm — 5
- new indication or use of a previously approved compound — 6

Drugs

The letter portion of the rating indicates the drug's therapeutic potential. Each drug receives an A, B or C rating.

- important therapeutic gain because of increased effectiveness or safety for treatment of a disorder not adequately treated by other available drugs — A
- modest therapeutic gain because of reduced side effects, greater convenience, less frequent doses, or decreased cost — B
- little or no therapeutic gain over previously available similar drugs — C

Supplemental letters from the second half of the alphabet convey additional data. For example:

- **M** means the drug is marketed abroad already
- **P** a change in packaging or container that has important features
- **S** application sensitive by virtue of publicity or congressional interest
- **T** important toxicity problem such as carcinogenesis in animals
- **U** drug is likely to be given to children

Recently, the FDA has added the designation "AA," which applies to agents used in the treatment of AIDS. Drugs with an AA rating receive the highest priority for review within the agency. A glance at the number and letter designation tells whether, in the FDA's opinion, a widely promoted drug is a medical breakthrough or offers modest, slight or no benefit compared to existing drugs of its type. For a physician, it may be important to know that a widely promoted new drug rates, for example, a 1-C in the opinion of the FDA. In other words, although the drug is a new molecular entity, it offers little or no therapeutic gain over previously available similar drugs.

Examples of FDA Ratings for Some Recently Approved Drugs

<i>FDA</i>	<i>DRUG</i>
RATING	
1A(AA)	ganciclovir (Cytovene) antiviral for treatment of CME retinitis
1A	clomipramine (Anafranil) the first effective drug therapy for obsessive compulsive disorder
1B	ketorolac (Toradol) an injectable nonsteroidal anti-inflammatory drug for moderate to severe pain without risk of addiction
1C	cefmetazole (Zefazone) a cephalosporin antimicrobial for treatment of a variety of bacterial infections
2C	cefuroxime axetil (Ceftin) an ester of cefuroxime, approved for oral administration (the sodium salt was previously approved)
3C	betaxolol (Kerlone) a cardioselective beta adrenergic blocker approved previously in an ophthalmic solution for glaucoma
4C	lisinopril and hydrochlorothiazide (Prinzide) new combination product of two previously approved drugs
5C	ibuprofen oral suspension 100 mg/5ml (Pediaprofen) a product containing the same drug, strength and dosage form already available under the trade name Children's Advil
6C	atenolol (Tenormin IV) for treatment of acute myocardial infarction in addition to hypertension and angina pectoris

Addition/Deletions to the CHMCA Formulary

Additions

Marinol (Dronabinol) 2.5mg and 5mg caps (C-11) Restricted to Hematology/Oncology Service

Dolophine (Methadone) 10mg/ml injection (C-11) Restricted to Anesthesiology Service

Pepcid (Famotidine) 20mg tabs, 40mg/5ml susp, 20mg/2ml injection

Vasotec IV (Enalaprilat) 1.25mg/ml injection

Dome-Paste 4"×10yd bandage (Unna's Boot, improved)

Deletions

Anadrol-50 (Oxymetholone) 50mg tabs

Darvon (propoxyphene) 32mg caps (C-IV)

It is important not to misinterpret the information. For example, a new 1-C drug, which offers no therapeutic gain, may offer a significant economic advantage over its competitors. In fact, nearly one-half of all newly approved distinct chemical entities are rated 1-C.

Also, it should be noted that there are no ratings for new vaccines or products of biotechnology such as recombinant human erythropoietin because the FDA's Bureau of Biologics does not participate in the rating system.

Obituaries

EDWIN ARTMAN, MD, Sun City, FL; Ohio State University College of Medicine, 1935; age 80; died January 4, 1991; member OSMA and AMA.

DORENCE S. COWLES, MD, Columbus; Yale University School of Medicine, New Haven, CT, 1925; age 92; died December 13, 1990; member OSMA and AMA.

WILLIAM F. DAVIS, MD, Ashtabula; Ohio State University College of Medicine, 1955; age 64; died January 3, 1991; member OSMA.

ALEXANDER FREED, MD, San Rafael, CA; Case Western Reserve University School of Medicine, 1925; age 89; died December 30, 1990; member OSMA and AMA.

ROBERT L. FRIEDMAN, MD, Columbus; Registrable Qualification Granted by Scottish Conjoint Board, Scotland, 1940; age 77; died December 15, 1990; member OSMA and AMA.

WILLIAM J. HORGER, MD, East Liverpool; Case Western Reserve University School of Medicine, 1932; age 82; died November 29, 1990; member OSMA and AMA.

HERMAN KARRER, MD, Plain City; Ohio State University College of Medicine, 1937; age 78; died December 20, 1990; member OSMA and AMA.

VARSHA N. KUMBHANI, MD, Dayton; University of Bombay, Bombay, India, 1972; age 41; died December 24, 1990; member OSMA.

ABE A. LICHTBLAU, MD, Canton; University of Michigan Medical School, Ann Arbor, MI, 1930; age 84; died December 12,

1990; member OSMA and AMA.

SAMUEL N. MAIMON, MD, Dayton; Vanderbilt University School of Medicine, Nashville, TN, 1931; age 83; died January 7, 1991; member OSMA and AMA.

FRANK MAYFIELD, MD, Cincinnati; Medical College of Virginia Commonwealth University School of Medicine, Richmond, VA, 1931; age 82; died January 2, 1991; member OSMA and AMA.

RAYMOND C. MCKAY, MD, Cleveland; Case Western Reserve University School of Medicine, 1920; age 98; died December 13, 1990; member OSMA and AMA.

PAUL E. NOONAN, MD, Warren; George Washington University School of Medicine, Washington, D.C., 1934; age 80; died December 26, 1990; member OSMA and AMA.

MARVIN ROLLINS, MD, South Russell; Case Western Reserve

University School of Medicine, 1952; age 67; died December 5, 1990; member OSMA and AMA.

OSCAR F. ROSENOW, MD, Columbus; University of Wisconsin Medical School, Madison, WI, 1931; age 83; died December 14, 1990; member OSMA and AMA.

RAPHAEL E. SAYEGH, MD, Akron; Abbasis Faculty Medicine University Ein Shams, Cairo United Arab Republic, 1968; age 46; died December 16, 1990; member OSMA.

DARREL T. SHAW, MD, Lawrence, KS; University of Kansas School of Medicine, Lawrence-Kansas City, KS, 1935; age 78; died December 28, 1990; member OSMA and AMA.

WALTER B. WEBB, MD, Ravenna; Case Western Reserve University School of Medicine, 1939; age 75; died December 6, 1990; member OSMA and AMA.

Political Activist . . . continued

quality of health care and not be self-serving. Becoming active in political campaigns at all levels is important. We must actively support those candidates who share our goals and concerns about the future of health care in this country. This support may involve direct door-to-door campaigning, financial support and letter writing. Strong support for Ohio Supreme Court Justice Craig Wright by the Ohio State Medical Association was very important in his re-election.

Finally, physicians should be prepared to seek political office themselves. There are no physicians in the Ohio General Assembly, but there are many

attorneys. We need to increase *medicine's* representation in government — at *all* levels.

Physicians need to act, and act now before it's too late. When you are asked to write your representatives in Congress — write. Participate in the campaigns of those individuals you support — and consider running for office yourself. We need this commitment of time and energy from our colleagues if medicine is to flourish in the future. **OSMA**

Mark A. Bechtel, MD, is President-Elect of the Ohio Dermatological Association and chair of the Legislative Committee.

Research

Diet/life span link?

Does reducing calorie intake increase life expectancy? That's the question a researcher at the University of Dayton hopes to answer in a study launched last fall.

Madeline Dellow, an assistant professor of human ecology, is exploring why a low-calorie diet often results in longer life spans.

For half a century, laboratory rats on low-calorie diets have lived three or more years instead of the usual two. "This is the equivalent of a human living 130 or 140 years," says Dellow. The rats also seems to avoid long-term, debilitating diseases, she adds.

The study will concentrate on the effects of a low-calorie diet on the endocrine system, and on the way proteins and enzymes bind in the body. Evidence suggests that a low-calorie diet allows proteins and enzymes to work more efficiently.

Middle-aged rats will be used during the study to determine whether a low-calorie diet is beneficial if it begins later in life. **OSMA**

Titanium insulin pump for diabetics is implanted

Titanium implanted insulin pumps are being tested on diabetic patients at St. Thomas Medical Center in Akron.

The pump, weighing just seven ounces, is implanted under the skin of the abdomen where it injects small amounts of insulin into the peritoneal cavity. A radio controller, no larger than the size of a TV remote control, can signal the pump to release extra insulin



to help burn up any increased amounts of sugar.

The pump is being tested on 100 people in both the U.S. and France and, if the trial goes well, the pump's manufacturer hopes to receive Food and Drug Administration approval by late this year or early next year. **OSMA**

able to pinpoint the sequence of snail DNA that makes the enzyme HMG co-A reductase, which is critical to snail egg production.

The team has cloned the DNA and hopes to use the enzyme to shut down snail reproduction, which could lead to a preventative vaccine. Presently, schistos is treated with two drugs — praziquantel and metrifiponate. **OSMA**

Third World health

A vaccine against such scourges as snail fever, lymphatic filarosis and river blindness (all of which are very real problems in Third World countries) may be just around the corner if studies conducted by researchers at Case Western Reserve University are successful.

The researchers, who have been focusing their study specifically on schistos or snail fever, have been



Research

Clevelanders studied for heart attack risk

What percentage of people, when warned they are at risk for a heart attack, will actually change their lifestyle?

That's the question being asked by the "National Heart Attack Risk Study," developed by William C. Roberts, MD, chief of pathology at the National Heart, Lung and Blood Institute, and editor-in-chief of the *American Journal of Cardiology*.

Cleveland is one of the areas where the behavior of 500,000 Americans, at risk of heart attack, will be monitored over the next five years. Every six months, hospital staffs will test participants for high cholesterol levels, diabetes, high blood pressure, obesity and smoking — the five risk factors. The presence of any of these factors puts the patient at risk, and he or she will be instructed to see his or her doctor. Those without patients will be referred to physicians.

The results from all screenings will be entered into the project's national data base for later study. **OSMA**

Dysfunctional syndrome studied

Researchers at the University Hospitals of Cleveland recently received a \$485,000 grant to study why some hospitalized elderly patients improve physically, but lose some of their normal functioning ability. For these patients, the disease or illness that brought them into the hospital clears up, but during the stay, they lose some ability to walk, bathe, dress themselves or perform other



simple tasks of daily living.

"The illness gets better, but the patient gets worse," explains Robert M. Palmer, MD, a geriatric specialist who is conducting the study with C. Seth Landefeld, MD.

The pair refer to this phenomenon as "dysfunctional syndrome," and claim that up to 30% of patients 75 years or over may suffer from it.

Dysfunctional syndrome is a new concern, they say, because patients over 75 are a relatively new phenomenon.

Part of the grant, provided by the John A. Hartford Foundation,

was used to remodel a hospital unit to determine if a non-hospital atmosphere can reduce incidence of the syndrome. In addition, greater emphasis in the new unit is placed on how well a patient walks, sleeps, bathes and dresses — some of the functions lost by sufferers of dysfunctional syndrome. **OSMA**



New, fast test for cancer

Technology pioneered at Ohio State University, Columbus, may soon yield a new and simple test for early detection of leukemias and lymphomas that might replace biopsies and bone marrow tests.

The test is rapid, easy to use and highly accurate.

The test, which uses the patient's blood or urine, can

Research

produce a result in as little as two hours, and can be used to detect leukemias and lymphomas in adults and children.

Once a prototype is developed, clinical trials will begin, then it will go to the Food and Drug Administration for final approval.

OSMA

Solvents' effects on workers

A half dozen University of Cincinnati researchers have targeted six solvents, commonly used by the military and the

nation's industries, to determine whether or not they produce genetic defects.

The solvents: Trichloroethane, methylene chloride, methylethyl ketone, toluene and xylene are used by millions of workers across the country, and because they are used to degrease engines and strip paint, may be found in some homes as well.

"The majority of industries use one or more of these solvents," says Grace Lemasters, the study's principal investigator. "Some of these agents have been shown to be mutagenic."

Although studies have already been done on the neurological effect of solvents, the UC study

will focus on the genetic effect that internal doses and external exposure to solvents may have on workers' children.

"The most likely effect would be early fetal loss, but it could, potentially, be a warning sign for possible risk of childhood cancer," says Lemasters. OSMA

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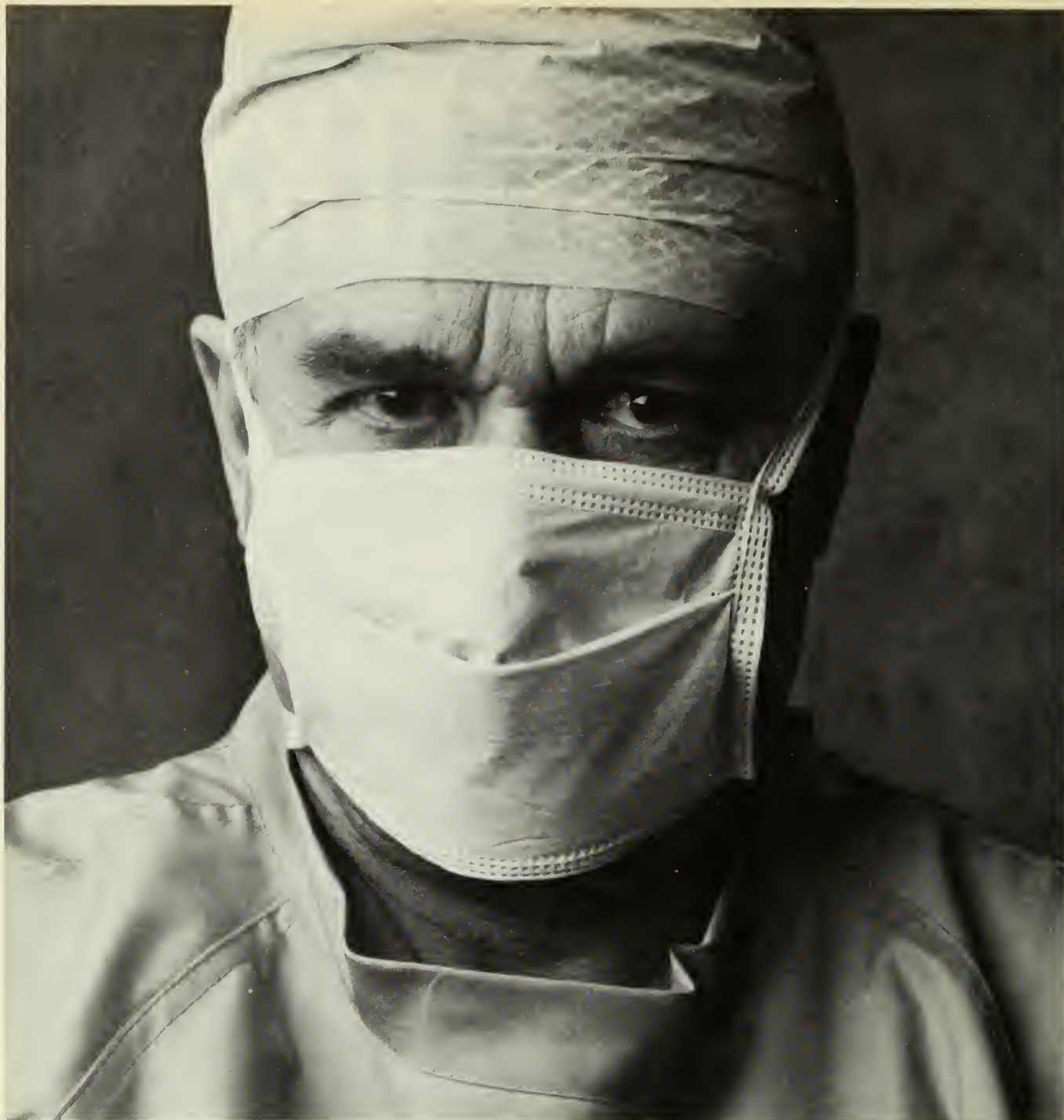
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Consultations and the Risks of Malpractice

Claims files and comments from malpractice defense attorneys reflect increased concern over the proper use of medical consultations and referrals for second opinions. Allegations of “failure to diagnose” are surfacing

as a leading cause of litigation — with claims and criticisms frequently focusing on the timing and appropriateness of consultation. Of special concern are cases related to cancers, complications of pregnancy and heart diseases.

Here are some recommendations that may help lessen the risk of a malpractice lawsuit.

Several key factors need to be considered when deciding if consultation or referral are necessary:

Competency. If the patient's condition is beyond the physician's knowledge, ability or capacity to treat, there may be a duty to refer the patient to the management of another physician.

Treatment Effectiveness. In

monitoring the treatment you have chosen, the patient's progress — or lack of — should be reflected in your records. If the expected result is not being achieved, you may want to consider the need for possible consult or referral, and discuss this with the patient.

Documentation. The patient's record should contain sufficient documentation to evidence when and why treatment was initiated. This includes a record of response to treatment and discussion of alternatives with the patient — especially when symptoms persist or when therapy fails to cure those symptoms.

Communication. The patient needs to understand that the diagnosis and treatment are indeed a matter of science — and it is only through trial and evaluation that a determination can be made whether optimal results have been achieved.

In patients in whom you suspect a tumor, cancer or other serious problem, it is important *not* to over-assure the patient about the potential outcome of findings by a consultant. Your support and reassurance are helpful and appreciated, but there is danger in giving an impression of hope or a prognosis that is unrealistic.

There are occasions when a patient may doubt your ability when a referral becomes necessary.



Loss Awareness

Do not allow this to distance you from the patient. Similarly, you should not become defensive if a patient or family member questions you about the referral.

Calmly and factually state your rationale for referral and your concern for the patient. A patient's hostility over costs can be minimized, to a degree, by informing the patient ahead of time about a consultant's fees or the probable cost of tests and further studies.



If you are the referring physician:

- Clearly communicate to the patient the need for the role of the consultant.
- Establish a follow-up system to determine if the patient has proceeded with the recommended consultation.
- If time is crucial, call the consultant to assure a prompt visit and advise the consultant of the degree of urgency.
- Define the scope of consultation and communicate the specific problem or symptoms to be addressed.
- Clarify which physician will be responsible for overseeing and coordinating the patient's treatment after the initial consultation. This can prevent duplication of procedures and contraindicated treatments.
- Communicate directly with consulting physicians or other treating physicians, rather than relying exclusively on chart notes to advise of the patient's condition.
- If you disagree with the consultant's recommendations, document why you choose not to follow the advice. However, do not disagree with other physicians in the presence of the patient or family. Make note of

conversations with consultants in the patient's chart, especially when a change in orders or care occurs.

If you are a consultant:

- Define the scope of your consultation in writing, specifying the nature of the request by the attending physician.
- Since test results or treatment orders from the referring physician may not have been completed at the time of your examination, indicate the information that has been reviewed by you.
- Urgent findings from outpatient consultations should be verbally reported to the referring physician, with a dictated report to follow. For hospitalized patients, where the consultation report is dictated, a handwritten interim note may be indicated.
- To protect yourself from potential liability, complete your written report in a timely manner. In addition to your recommendations, it should serve to clarify any confusion over misunderstood advice, or instructions to the patient or referring physician.

- It is important to clearly communicate to the referring physician when you are signing off the case. Do not rely on progress notes alone as a means of informing the attending physician that you will no longer follow the patient.
- Document all related conversations with the referring physician; all follow-up visits should be documented in the progress notes along with findings and any modifications in treatment.

Defense of a malpractice claim often is made more difficult because there is not adequate charted information regarding the flow of care and response to treatment. The suggestions above may help lessen your risk of liability and provide documentation in the event a malpractice suit is filed. **OSMA**

The Loss Awareness Bulletin is provided each month through the OSMA Task Force on Professional Liability and its subcommittee on Loss Awareness with the assistance of the Physicians Insurance Company of Ohio.

One Of A Kind



Zantac[®]
ranitidine HCl/Glaxo 150 mg and
300 mg tablets

Please see Brief Summary of Prescribing Information on adjacent page.

Glaxo/ROCHE



One Of A Kind

Zantac®

ranitidine HCl/Glaxo 150 mg and 300 mg tablets

Zantac® 150 Tablets
(ranitidine hydrochloride)

Zantac® 300 Tablets
(ranitidine hydrochloride)

Zantac® Syrup
(ranitidine hydrochloride)

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIONS AND USAGE: Zantac® is indicated in:

1. Short-term treatment of **active duodenal ulcer**. Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer**. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD)**. Symptomatic relief commonly occurs within one or two weeks after starting therapy. Therapy for longer than six weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS:

General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy.

2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although Zantac has been reported to bind weakly to cytochrome P-450 *in vitro*, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/d.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella*, *Escherichia coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

Pregnancy: Teratogenic Effects: Pregnancy Category B: Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with Zantac®. The relationship to Zantac therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to Zantac administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

Cardiovascular: As with other H₂-blockers, rare reports of arrhythmias such as tachycardia, bradycardia, atrioventricular block, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and rare reports of pancreatitis.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid intravenously for seven days, and in 4 of 24 subjects receiving 50 mg qid intravenously for five days. There have been occasional reports of hepatitis, hepatocellular or hepatocellular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually

BRIEF SUMMARY

Zantac® 150 and 300 (ranitidine hydrochloride) Tablets
Zantac® (ranitidine hydrochloride) Syrup

reversible, but in exceedingly rare circumstances death has occurred.
Musculoskeletal: Rare reports of arthralgias.

Hematologic: Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia have been reported.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by Zantac and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when Zantac has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Integumentary: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling).

Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice daily. An alternate dosage of 300 mg or 20 ml (4 teaspoonfuls equivalent to 300 mg of ranitidine) once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison syndrome): The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day. In some patients it may be necessary to administer Zantac® 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/d have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

GERD: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30° C (59° and 86° F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 ml in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25° C (39° and 77° F). Dispense in tight, light-resistant containers as defined in the USP/NF.

July 1990



Glaxo Pharmaceuticals

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Edouard Manet

By James G. Ravin, MD

The avant-garde artist Edouard Manet broke with traditional French painting in his technique and in his subject

matter. Although he spent several years as a student in the studio of Thomas Couture, a mainstream academician, Manet turned to Spanish art, particularly that of Velasquez, for inspiration. There he found large flat areas of background and bright colors, which became features of his style. He also found Japanese art appealing in its simplification of forms.

Manet was friendly with many of the Impressionists,

especially Monet and Renoir. He was older than them and they looked up to him, despite the fact that he refused to show his work at any of the Impressionist exhibitions. He preferred to try to gain acceptance at the official Salon exhibitions. Manet's subject matter, particularly his nudes,

often shocked and offended the critics and the public. His style was also criticized as being too sketchy and unfinished.

Manet had little success at the Salon until 1880, when his portrait of Antonin Proust received a generally favorable response. Not being an aggressive female nude placed in a strange setting, it was not offensive. Manet and Proust were childhood friends who had studied together in Couture's studio. Proust was a journalist, critic and politician. He became Minister of Fine Arts in 1881 and quickly obtained a high honor for Manet, Chevalier of the Legion of Honor. After Manet's death, Proust helped arrange a memorial exhibit for him and wrote a series of articles about him, including this description: "It has frequently been said that the greatest service that he rendered to art was to lighten the painter's palette, to make luminous and dazzling what his predecessors had lost in darkness and useless half-tones. He achieved this by watching and observing attentively the play of light and the relation of tone values. For him, painting was such a pleasure that in whatever he saw, whether it was a still life, a living person or a landscape, he always sought simplicity, eliminating everything complicated and fussy."¹

In a letter to Proust, Manet



Art and Culture

described his portrait: "Your picture has been on exhibition in the Salon for the last three weeks — badly hung near a door, on a divided panel, and even worse, criticized. But it seems to be my lot to be slanged and I accept it philosophically.

"However, you have no idea how difficult it is, my dear friend, to place a single figure on a canvas, and to concentrate all the interest on that one and only figure without its becoming lifeless and unsubstantial. Compared with this, it's child's play to paint two figures together who act as foils to each other . . .

"Your portrait is painted with the utmost sincerity possible. I remember, as if it were only yesterday, the quick and simple

way I treated the glove you're holding in your bare hand and how, when you said to me at that moment, 'please, not another stroke,' I felt in complete sympathy with you and could have hugged you."²

In his late 40s, Manet became seriously ill from what was initially felt to be rheumatism or phlebitis. He collapsed on the street in 1879. A course of hydrotherapy was undertaken in 1880. The diagnosis soon became locomotor ataxia (tabes dorsalis) due to syphilis. He suffered severe pains in the legs and was forced to walk with a cane. In 1883 his left leg was amputated above the knee due to gangrene, but he soon developed fever and chills and died about 10 days after the amputation at 50

years of age. **OSMA**

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Manet, "Antonin Proust"

Oil on canvas, 1880

Toledo Museum of Art.

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James G. Raven, MD, Toledo, is chair of the Art and Culture Committee and a member of OHIO Medicine's Advisory Board.

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How to Get Patients to Pay

Aside from dealing with third-party payors, getting a patient to pay his or her bill promptly can be one of the most frustrating aspects of daily practice.



"People pay their medical bills pretty far down the list," says Robert J. Hecht, program director of the AMA's Department of Practice Management. To illustrate, Hecht, who was in Columbus recently to conduct a

seminar cosponsored by the OSMA titled "Starting Your Practice," displayed a chart showing exactly where your patient's dollar goes: The top three, not surprisingly, were mortgage/rent, utilities and auto. Doctor and hospital bills, however, ranked a lowly #9 and #10, respectively. (Much of the reason is because patients don't perceive medical bills as pressing and because such accounts normally don't charge interest — something, by the way, that is considered perfectly ethical and acceptable to do.)

But it doesn't necessarily have to

be that way, says Hecht, if physicians follow several simple steps, the first of which is to inform any new patient over the phone of your office's payment policies. Next, it should be determined what kind, if any, of health insurance the patient has. Finally, your office staff should note the patient's responses. "That's important," says Hecht, "so that if the patient doesn't comply, your staff will be on top of things."

While letting your patients know up front what your payment policies are, it's equally important to follow up on outstanding accounts, and to do so promptly. For this, Hecht suggests physicians set up a 120-day collection timetable (though some physicians may want to shorten it to 90 days): Always provide monthly bills; at 60 days a collection letter of about 30 words should be included, and it should be signed by a staff member; at 90 days, include a letter with stronger wording; and at 120 days, tell the patient that if they don't contact your office promptly, the account will be turned over to a collection agency.

Many patients will finally pay after the fourth letter, Hecht says, "because they think it's their last chance." Also, some fear that being turned over to a collection agency will ruin their credit rating (not always true, notes Hecht).

In addition to sending letters, physicians may want to contact delinquent patients by phone,

Practice Management

which, Hecht says, “tends to be a little more personal.” When making such calls (Hecht suggests dinnertime and Saturday mornings), office staff should identify themselves and ask for the patient personally — never reveal the debt to someone else. When the patient is contacted, then, arrangements should be made to collect what’s due. However, Hecht notes, “this is an art, and your staff really has to get good at it.”

Of course, some patients will never pay their bills. Warns Hecht: “The quicker you get the money the better, because after six months, the chances of you collecting is probably less than 50%.”

In those cases, contracting with a collection agency may be necessary. Such agencies, notes Hecht, typically charge 30% to 50% of what they collect, and they will usually contact patients by letter or phone. “If you want them to go further,” says Hecht, “you can actually have the patient sued,” though it is unusual. “Another alternative is to hire your own attorney,” says Hecht, who adds that, “sometimes a simple letter from an attorney to a patient is enough to get them to pay.”

Another less common road is to take the patient to small claims court, where it’s relatively easy (and inexpensive) to prove payment is overdue. “You can get a judgment,” says Hecht, “which doesn’t ensure payment, but it does give you ammunition” (such as the ability to garnish wages).

If these measures don’t work after a year, Hecht says the loss should be written off.

Amazingly, says Hecht, some patients who fail to pay their bills will attempt to continue seeing the



physician. In that case, Hecht suggests the physician inform the patient that a cash payment is due at the time of the visit. If the patient claims an inability to pay, the physician should see the patient one last time and terminate the doctor-patient relationship by doing the following:

- Give written notification of the termination
- Give the patient a reasonable time period to find a new physician (30 days is common, but it depends on the patient’s medical situation)
- Send the letter registered mail/return receipt requested
- Sign the letter personally

Finally, Hecht says, give the patient the number of the local medical society but refrain from recommending a specific physician.

OSMA

Collection Policy Hints

- Inform any new patients of your office policies up front.
- In collection letters, use the phrase “We have not received your payment” rather than “You have not sent your payment.”
- Never mark bills with “Past Due” on the outside.
- Never send past-due notices on postcards.
- Never call patients at work to discuss their past-due bills — try them at dinnertime or on Saturday mornings, if they are difficult to reach.

Lazarus Complex

(Lazarus syndrome, near-death syndrome)

By Alvin Rodin, MD
and Jack Key

Experiences before resuscitation after cessation of vital signs due to cardiac arrest has been named after the biblical Lazarus.^{1,10} Some patients have amnesia of the event, and

some remember going into nothingness, fading out of lights, "feeling life flooding into you," and hearing someone say, "My God, his heart has stopped."² One patient felt his atheistic beliefs confirmed as "There is nothing there." Another had his faith vindicated as "There seemed to be music and

angels singing on the other side." Moody's book on life after life³ addresses the same situation, but finds that it is common to be outside of one's body, moving through a long tunnel, glimpsing the spirits of dead relatives and friends, and seeing a warm light at the end of the tunnel. Such perceptions have also been experienced by children.⁴ Return to the land of living may be followed by symptoms of anxiety,

depression and a feeling of alienation.⁵

The study of near-death experiences has been considered important in determining the existence of survival after death.⁶ A more pragmatic explanation is that the type of experience is influenced by "cultural and psychological factors, sensory deprivation and reflex adaptive responses to stress."⁷ More specifically, the effects of hyperpnea and hypoxia on the temporal lobe have been suggested.⁴ Ischemia of the occipital lobe can result in constriction of visual fields (tunnel vision).⁸ There is no indication that the biblical Lazarus experienced such phenomena.

Lazarus of Bethany, the brother of Martha and Mary, died after an unspecified illness.⁹ He was raised from the dead after four days by Jesus. "[Jesus] called out with a loud voice, 'Lazarus, come out!' Out came the one who had died, feet and hands tied with grave clothes, and his face wrapped in a towel. Jesus told them, 'Unbind him and let him go.' " Jesus himself was raised from the dead. His immediate cause of death while being crucified has been attributed to hypovolemic shock and exhaustion asphyxia.¹¹

There are two other instances of



Medical Eponyms

restoration of life by Jesus in the Bible. The only son of a widow in a town near Nain was brought back to life by telling him to rise.¹² Jesus performed a similar miracle for the daughter of Jairus, a ruler of a synagogue.¹³ It has been suggested that some of these raisings of the dead may actually represent revival of patients suffering from catalepsy.¹⁴ However, the effect of such therapy without drugs is not much less than miraculous.¹⁵ Paul performed an even more remarkable miracle by reviving Eutychus, who had been killed by a fall from a third-story window after having fallen asleep on the ledge.¹⁶ The cause of death is not given for Tabitha, a disciple in Joppa who was returned to the living by Peter through prayer and invoking "Tabitha, arise!"¹⁷ Several dead biblical children were revived by a combination of physical efforts and prayer (see Elisha Method).

A nonbiblical variant of resuscitation after death is the zombie, related to the Haitian religion, vodoun, or voodoo.¹⁸ A zombie is an individual raised by evil sorcerers from the grave in a trance and forced to work as a slave. The zombie condition may have had its origin from the effects of tetrodotoxin, a potent neurotoxin found in the tissues and organs of the blowfish. Poisoning can simulate death due to complete paralysis, although the individual may remain conscious.

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Sources for Clinical Clips

- | | |
|---------------------------|--|
| Breast cancer | <i>Cincinnati Post</i> ,
Jan. 7, 1991 |
| SIDS statistics | <i>Cincinnati Enquirer</i> ,
Dec. 22, 1990 |
| Strokes, drug use | <i>Cincinnati Enquirer</i> ,
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| Physician's workday | <i>Scientific American Medicine</i> ,
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Employment Opportunities

ANESTHESIOLOGIST — Excellent opportunity to direct anesthesia at Bluffton Community Hospital, a 42-bed hospital located in a college community, one hour south of Toledo, one and one-half hours north of Dayton, off I-75. Shared call coverage. Board-eligible, Board-certified. Benefit package includes salary, malpractice insurance, health insurance, disability, and other fringes with moving allowance. Send resume to Administrator, Bluffton Community Hospital, P.O. box 48, Bluffton, OH 45817-0048, or call collect (419) 358-9010 or FAX (419) 358-7406.

BOWLING GREEN, OHIO — Board-certified FP seeking associate. Well-established office with pharmacy and lab. Flexible arrangement and hospital support. Send CV to Kenneth Lee, MD, 18988 Gloucester Dr., Bowling Green, OH 43402 or call (419) 352-6248 (evening).

BUSY GENERAL INTERNAL MEDICINE PRACTICE — Serving western Columbus seeks BC/BE internist to join group. Send CV to Box 234, c/o OHIO Medicine, 1500 Lake Shore Dr., Columbus, OH 43204-3824.

CAMBRIDGE DEVELOPMENTAL CENTER — A 144-bed ICF/MR state facility is recruiting for psychiatrists, pathologists and physician administrators (medical director) to serve people with moderate, severe and profound mental retardation. Salary is commensurate with experience. Civil Service or contract employment available. Interested applicants should contact or send resume to the Personnel Office, Cambridge Developmental Center, Co. Rd. #35, Cambridge, OH 43725 (614) 439-1371, Ext. 409. "An equal opportunity employer."

CARDIOLOGY — Be a part of a thriving invasive cardiology group practice located in southern Indiana. Affiliated with a 590-bed regional referral center. Competitive salary plus malpractice insurance and other physician perks. Send CV to Don Hoit, 11222 Tesson Ferry Rd., Suite 203, St. Louis, MO 63123 or call 1-800-336-3963.

CLEVELAND SOUTH — Excellent compensation offered to full-time and part-time physicians at low-volume emergency department. Full malpractice insurance coverage. Benefit package available to full-time staff. Contact: Emergency Consultants, Inc., 2240 S. Airport Road, Room 26, Traverse City, MI 49684; (800) 253-1795 or in Michigan (800) 632-3496.

CLINICAL ASSOCIATES — Two positions for BC/BE internists at university teaching hospital. Principal responsibilities are coverage of innovative inpatient medical service in conjunction with research on health-care delivery. Other responsibilities include attending/teaching in ambulatory medical clinic and on medical wards. Positions available July 1, 1991. Contact George H. Goldsmith, MD, Director, Patient Care Programs, Department of Medicine, University Hospitals of Cleveland, OH 44106 (216) 844-3695. An equal opportunity employer.

COLUMBUS, OHIO — The Ohio State Highway Patrol, an equal opportunity employer, is seeking a physician to staff its health and fitness facility, located at the Training Academy. Primary duties include conducting daily sick call for trainees, conducting complete physicals and serving as the division's medical adviser in determining fitness for duty. Position is awarded to successful bidder on a yearly basis. Hours: 7:30 - Noon (approximately) Monday-Friday. Please direct inquiries and CV to Major Don Goodman, Ohio State Highway Patrol Academy, 740 East 17th Avenue, Columbus, OH 43211, (614) 466-4896.

FAMILY PRACTICE — Choose between several excellent family practice opportunities in Illinois, Wisconsin, Arizona and Maryland. Solo and group positions available with guaranteed salaries and competitive benefit packages. To discuss these positions in confidence, please call (800) 969-7715. Dan Jones, Gielow/Laske Associates, Inc., 306 North Milwaukee St., Milwaukee, WI 53202.

FAMILY PRACTICE — Private practice opportunity available to join busy well-established family physician located in London (25 miles west of Columbus). Candidate should be BE/BC. Guaranteed salary first year. Call or write Joe Barylak, Madison County Hospital, 210 North Main St., London, OH 43140. (614) 852-1372.

FAMILY PHYSICIANS NEEDED — Group, solo (with coverage) opportunities for BE/BC, residency-trained family practice physicians in economically strong, attractive, family-oriented community 45 miles from Columbus and Dayton. Offices next to well-equipped 73-bed JCAHO-accredited hospital with new surgical and emergency facilities. Good subspecialty availability. Hospital provides competitive financial package, including income guarantee. The primary guarantee is a growing community that need more primary care physicians. Contact: Gary Schenkel, Mercy Memorial Hospital, 904 Scioto St., Urbana, OH 43078. (513) 653-5231 (office), (513) 653-4089 (home).

GENERAL SURGEON OPPORTUNITY — Expanding northeast Ohio multispecialty group has an opportunity for a general surgeon. The Ashtabula Clinic offers good compensation and earning potential within the professional and financial support of a multispecialty group. The Ashtabula area, located on the shores of Lake Erie, combines the advantage of a small town, with easy access to the major metropolitan centers of Cleveland and Erie, PA. For additional information call or write: Ashtabula Clinic, Inc., 430 West 25th Street, Ashtabula, OH 44004. Attn: Jim Graeca, Administrator (216) 992-4422.

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INVASIVE (NON-ANGIOPLASTY) CARDIOLOGIST — Four-physician, single specialty cardiology group has an immediate opening for a BE/BC invasive cardiologist. Fully equipped cardiovascular labs are expanding and an excellent cardiovascular surgery program is established. The practice serves a large and expanding regional referral area in mid-Michigan. Generous compensation and early partnership are available. Send CV to: The Heart Group, P.C., Attn: N. Polzin, 4701 Towne Centre Road, Suite 201, Saginaw, MI 48604.

MEDICAL OPHTHALMOLOGIST — Part-time BE/BC ophthalmologist to associate with well-established ophthalmic practice in northeast Ohio. This private practice has superb practice environment with new facility, well-trained staff and excellent equipment. Send curriculum vitae to: Box 232 c/o OHIO Medicine, 1500 Lake Shore Dr., Columbus, OH 4320-3824.

MEDICINE — PEDIATRICS — OB/GYN — Group Health Associates, Inc., a 60-member multispecialty group practice, is accepting CVs from Board-eligible/Board-certified physicians in the above specialties interested in practicing in suburban Cincinnati. Continued growth permits us to plan expansion of our medical group this summer and early fall. Our physicians practice medicine, leaving the business side of medicine to our professional management staff. All of our full-time physicians have the opportunity to participate in the ownership of the medical group, elect the Board of Directors and share in determining the group's direction. There is a spirit of collegiality among our physicians, and our practice environment is enthusiastic. Many of our staff are involved in residency training programs. Our compensation system/fringe benefit plan is very comprehensive. For further information or to be considered for a position on our staff please send a cover letter and your CV to SEARCH COMMITTEE, GHA, 2915 Clifton Avenue, Cincinnati, OH 45220.

NON-INVASIVE CARDIOLOGIST — Four-physician, single specialty cardiology group has an immediate opening for a BE/BC non-invasive cardiologist. Echo, doppler, holter and treadmill are established in-clinic. Full invasive and surgical programs are established. The practice serves a large and expanding regional referral area in mid-Michigan. Generous compensation and early partnership are available. Send CV to: The Heart Group, P.C., Attn: N. Polzin, 4701 Towne Center Road, Suite 201, Saginaw, MI 48604.

OB/GYN PHYSICIAN — Board-certified admissable OB/GYN physician needed to establish practice in London/West Jefferson area due to retirement of local obstetrician. Growing communities within 25 miles of Columbus. Strong support available to assist to relocate and establish practice. Call or write Joe Barylak, Madison County Hospital, 210 North Main St., London, OH 43140. (614) 852-1372.

OCCUPATIONAL MEDICINE PHYSICIAN — Physician group practicing occupational medicine in Toledo, Ohio. Established/growing practice. Excellent salary and benefits. Experience preferred but good clinical background will be considered. Send Curriculum Vitae to OCCT, 6855 Spring Valley Drive, Suite 160, Holland, OH 43528. Daytime phone: (419) 865-4448.

OHIO — Near Columbus. \$120,000. CME, insurance and medical benefits. Primary care physician to join diagnostic center. Full or part time. Flexible scheduling. No OB. No call. Partnership. Call Louis Fairfield (513) 843-4545.

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HAPPY DOCTORS' DAY!

President George Bush has proclaimed March 30, 1991 as National Doctors' Day, and House Joint Resolution #492 and Senate Joint Resolution #272 have been passed by our Washington legislators to recognize the invaluable contributions physicians make in caring for the sick, advancing medical knowledge and promoting improved public health. Honor your doctors on March 30.

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OHIO, CLEVELAND — Experience the renaissance of this great midwestern city with a work schedule that allows you a lifestyle with defined hours, plenty of personal time and an attractive practice setting where you can provide both continuing and episodic care in an urgent care setting. Base stipend of \$87,000-\$110,000 (for 40-hour week) plus FFS compensation; 3 weeks vacation; on-call coverage; malpractice, health and dental insurance; profit sharing; buy-in/partnership opportunities. For more information contact Mitchell Leventhal, MD at (216) 642-1440, or send CV in confidence to 6133 Rockside Rd., Suite 10, Independence, OH 44131.

PITTSBURGH AREA — New fee-for-service ED group at The Medical Center in Beaver, Pennsylvania is seeking an associate director, full-time and part-time emergency physicians for this 475-bed Level II center. Double and triple coverage during peak periods provides reasonable patient load. New fast track area, excellent medical staff back-up, CEN-certified ED nurses, and full administrative support. Outstanding compensation and paid malpractice insurance. Benefit package available to full-time staff. Board-eligibility or certification in emergency medicine or primary care specialty, and ACLS required. Contact: Karen Remai, Emergency Consultants, Inc., 2240 S. Airport Rd., Room 26, Traverse City, MI 49684; (800) 253-1795.

PRIVATE PRACTICE OPPORTUNITIES — Exist in southern Indiana, affiliated with a 590-bed hospital. Specialties include internal medicine and family practice. Competitive compensation plan and attractive partnership arrangement available. Send CV to Don Hoit, 12161 Lackland Road, St. Louis, MO 63146 or call 1-800-336-3963.

PRIVATE PRACTICE OPPORTUNITY — Exists in northwest Ohio, affiliated with a 50-bed county hospital. Twenty years old, very large practice involving general surgery and family practice. Posi-

tion available immediately due to illness. Competitive compensation package plan and partnership arrangement available. Will introduce, and possible sale of practice in six months. Interested party please send curriculum vitae, references and other pertinent information regarding availability and Ohio licensure to Box 231, c/o OHIO Medicine, 1500 Lake Shore Dr., Columbus, OH 43204-3824.

RADIOLOGY / ORTHOPEDICS / FAMILY PRACTICE / PEDIATRICS / OB-GYN / INTERNAL MEDICINE / PERIPHERAL VASCULAR SURGERY — Several attractive opportunities in INDIANA, NEBRASKA, WISCONSIN and MICHIGAN. A variety of practice settings. Single, multi-specialty, or solo opportunities. Contact Bob Strzelczyk to discuss your practice requirements and these positions at 1-800-243-4353. STRELCHECK & ASSOCIATES, INC., 10624 N. Port Washington Road, Mequon, WI 53092.

STUDENT HEALTH SERVICE OPENING — Ohio University is seeking an experienced physician to join the staff at the Ohio University Student Health Service. Position available July 1, 1991. Applications will be accepted until position is filled. Opportunity to live in an attractive small college town in a wooded, rural setting and practice in a comprehensive health service, emphasizing health education and preventive care as well as primary outpatient medicine. Prefer experienced pediatricians or family practitioners with strong background in office orthopedics and/or gynecology. Ohio licensure or eligibility for same is required. Annual salary for 12-month contract is \$56,000 to \$60,000 range plus fringes, including no night or weekend call, excellent health, life and liability insurance benefits, as well as state retirement plan and access to educational benefits and numerous recreational facilities. Contact John A. Cornwell, Administrative Director, Ohio University Student Health Service, 2 Health Center Drive, Athens, OH 45701-2991 (614) 593-1660 or FAX (614) 593-0179. Applications from women and minorities are encouraged.

TERTIARY CARE HOSPITAL IN CLEVELAND, OHIO, CURRENTLY SEEKING BC DIVISION DIRECTOR — To join group of four anesthesiologists, directing nine anesthetists through a team approach. Surgical schedule includes OHS, trauma, minimal pediatrics, no OB. Experience and interest in OHS desirable. Send CV to: Aldona T. Lyon, MD, Acting Director, Division of Anesthesiology, Saint Vincent Charity Hospital and Health Center, 2351 East 22nd Street, Cleveland, OH 44115.

URGENTLY NEEDED BC/BE ANESTHESIOLOGIST — Professional corporation. Call (419) 756-5133.

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Equipment

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IPG — Impedance phlebography and defibrillator (216) 365-6242.

Practice for Sale

GENERAL PRACTICE AVAILABLE — In Lakeview, Ohio. Call (419) 738-7531.

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Rosary Hall announces the new Recovering Professionals Treatment Program. The program offers:

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OCCUPATIONAL MEDICINE TRAINING — Intensive program beginning June 3-14, 1991 and continuing October 14-18, 1991 and one week from March 16-20, 1992. The one-week continuation portions may be taken in successive years. Clinical and administrative occupational medicine, epidemiology and biostatistics, industrial hygiene, toxicology, regulations, etc. 111 Cat. 2-A CME credits. 15th year. References from past participants provided. \$725 per week. Douglas Linz, MD, MS, U.C. College of Medicine, M.L. 182, Cincinnati, OH 45267, (513) 558-0046.

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Those who wish to place an advertisement 1/6-page in size or larger should contact the appropriate advertising representative:

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Medical Aids

Medical aids for disabled athletes

Disabled patients need no longer be spectators of their favorite sport if they would rather be participants instead, thanks to the Disabled Consumers Network, a three-year-old organization located in Kettering, Ohio. Recently, the DCN co-sponsored with Miami Valley Hospital's Rehabilitation Institute of Ohio a "recreation showcase" of adaptive sports equipment. About 60 groups displayed equipment for a variety of sports, ranging from water and snow skiing to bowling, tennis, even hang-gliding.

Anyone wishing to learn more about the equipment or who might be interested in linking a disabled patient to the network should

write: Disabled Consumers Network, PO Box 292379, Kettering, Ohio 45429. Or phone 513-225-3194.



This vacation, plan some (medical) sight-seeing

Physicians who don't mind taking a "bus-man's holiday" this year may want to pick up a copy of *Medical Landmarks, USA*, compiled by California physician Martin Lipp, MD. Over 20 of the landmarks he lists in his book can be found right here in Ohio, including Daniel Drake's gravesite, Dr. Bob's house (where Alcohol Anonymous was founded) and the Dr. John Harris Dental Museum (home of the first dental school in the world). Medical history buffs will also find answers to: What American surgeon invented granola, the vibrating chair and tanning lights? and What physician



invented artificial refrigeration as a means of cooling his yellow fever patients? Order from: McGraw-Hill, Inc., PO Box 400, Hightstown, New Jersey 08520.

Hot-lines for your resource file

Hot-lines are handy resources for both physicians and patients since they frequently offer the quickest means of obtaining information, education, referral and even training about specific health problems. Below are a couple of hot-lines to add to your practice's resource list:

National Anorexic Aid Society
hot-line:
614-436-1112
The Ohio AIDS hot-line:
1-800-332-AIDS



Treating migraines

Charles W. Theisler, MD, founder and director of the Headache Clinic of Northeastern Ohio in Austintown has just published a book, *Migraine Headache Disease* which compiles more than 150 conservative treatment methods for migraine headaches. Anyone wishing more information or who may be interested in ordering the book should call 1-800-638-8437.

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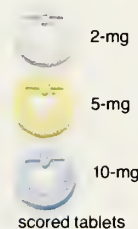
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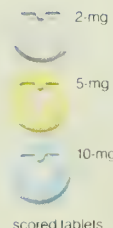
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VOL. 87, NO. 4

APRIL 1991

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COVER STORY

Discover the sites of Columbus at this year's OSMA Annual Meeting. Find out the best places to dine, to shop and to be entertained. Also, don't miss the complete meeting schedule found in this special annual meeting section. *Photo by Larry Hamill*

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Presidential Perspectives

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The Quality-Reimbursement Tie

AN OMEN OF THINGS TO COME?

In my last column, I told you that the OMB had refused to release to HCFA over \$100 million of Medicare contingency funds. Strong letters of protest were sent by OSMA and AMA to members of Congress and to Richard Dorrian, head of OMB.

Now, a major part of the funds have been released. We should feel pleased at this success — but it's hard not to feel frustrated that we had to spend a lot of time on what was a dumb idea to start with.

Third-party payors and the government constantly profess they are interested in maintaining quality care, but they care not at all about how it can be measured. They are cost-driven and know next to nothing about value. You would

think they have been in the business long enough to see the value rise. Defining quality and value will be one of the challenges of the '90s. Many CEOs of hospitals feel payors are bound to begin tying reimbursement to quality — and they fear the fact that there is presently little common agreement on what is quality of service. Presently, we have only anecdotal information and patient perception available. It seems to me that though I have serious questions about practice parameters, we better be about them.

New Jersey and Pennsylvania recently passed auto insurance reform acts that have significant points of interest for us, because some of our legislators and insurance companies are suggesting such legislation in Ohio.

Pennsylvania enacted an automatic 10% reduction in premiums and an optional no-fault provision — and inserted a clause allowing further reductions should motorists agree not to sue in less severe accidents.

Specifically, the legislature mandated that persons or institutions providing services and treatment to an injured person covered by insurance benefits cannot bill for greater than 110% of the prevailing charge at the 75th percentile — DRG or applicable fee schedule. The Assembly utilized the

**By John A.
Devany, MD**

**President of
the OSMA**



Presidential Perspectives

Medicare reimbursement allowance as the basis.

New Jersey has been even more onerous by increasing the license fee by 100 for the next seven years on attorneys, medical and osteopathic physicians, chiropractors, podiatrists and auto body repair shops, "in order to achieve a comprehensive program of indemnification from the injuries and damages that may arise out of the ownership or operation of motor vehicles."

It provides for a mandated fee schedule and provides a ban on balance billing. The bill caps mandatory benefits at \$250,000 — but allows for excess coverage at higher rates. The fee schedule for lawyers is not determined as yet; the medical fee schedule adopted is to incorporate the "reasonable and prevailing fees of 75% of practitioners in a region."

To show how the wording of a survey determines its outcome, a recent survey of 500 Americans by Northwest National Life Insurance Company showed 85% supported rationing if it keeps health care affordable and available. Fifty-two percent think a person ought to be able to pay for special care beyond what rationing will allow if they can afford it. Forty percent feel publicly funded health care should be rationed on the basis of chance of success for treatment. (Most agreed treatment should have a 59% chance of success to be paid by public money. Tell your local oddsmaker he or she has a whole new field opening up for action.)

The legislature in particular and society in general has absolutely no concept of the amount and the quality of care given gratis by doctors. I'm not talking about write-offs, I'm talking about goodness-giving, so it is a pleasure to see a recent article in the *Dayton Daily News* about the basement clinic at the St. Vincent

Hotel. Volunteer doctors and nurses treating the homeless on their own turf, knowing that if they didn't go there, most of the homeless they see would get no medical care at all — 'til their conditions get so severe they cram emergency rooms. As the *News* said, work with the homeless is draining, and it takes patience and a special bedside manner learned on the job. It is worthwhile, it can be satisfying. We know that greed does not crowd out our impulse to serve others, or, as George Bernard Shaw said: "The true joy of life is in being used for a purpose recognized by yourself as a mighty one — to be a force of nature instead of a cloud of grievances."

We constantly have to be alert for con men, no matter how smart we think we are. Recently, in southern Ohio, police intercepted a drug ring preying on unsuspecting

doctors by con artists posing as AIDS patients coming home "for therapy." Ring members used bogus medical histories and forms to try to get Dilaudid.

You will be noting that there have been changes in the format for the Annual Meeting. You will remember that you were questioned at the last meeting — about your desires — as to the mechanics for streamlining your meeting. Council is human; there is no perfect meeting. Trial and error and observation of how others do it really provides the only way we can learn. This is your meeting. I am there to try to facilitate the House's ability to get to its collective opinions with a minimum of acrimony. We do not want to streamline ourselves out of business. Bear with us. I'm sure you'll let us know how you feel. OSMA

NEXT MONTH'S ISSUE

- **Are third-party payors threatening the health of your patients?**
- **Meet Lou Barich, MD, a Hamilton physician who pushed for regulations that placed additional requirements on the city's tanning salons and won.**
- **Loss Awareness deals with stronger medical records and brushing up on key documents.**

A Measure of Support

IN DEFENSE OF THE MD DEFENDANT

“Hey, it can't be that bad! Let's see a smile.” Normally, this comment would elicit a warm smile or at least some acknowledgement that someone has noticed a usually cheery, confident person is depressed. Today, however, there is no

response, or the response is “You wouldn't understand.”

Finding time for dinner with friends or a game of golf seems a real problem now. Increasing amounts of time are spent at the

hospital reviewing charts and rereviewing lab tests and data as each new case seems to be accompanied with unique problems that differ from the routine.

The children find that, increasingly, the physician-parent is

preoccupied with thoughts of patients and time for play, for just talking is no longer available. The physician is busy scanning books and magazines, highlighting data that will substantiate and reaffirm his or her course of action with a patient, and hours are spent teaching lawyers the background for decision-making in the field of medicine. There are so many factors involved, and it is not easy to explain to a lay person that the judgment cannot always be the same for the same medical procedure because each person's medical condition is unique to special health risks or problems.

Hours of time are spent in depositions and defending oneself against actions that required total concentration — often at the expense of family birthdays, anniversaries or other special occasions. At times, neither the patient nor the physician's own family understands and appreciates the sacrifices. It is no wonder then that a physician could start to doubt his or her professional abilities.

To ask for reassurance seems to be admitting self doubt. After all, we are dealing with a competent, well-trained physician who has always put practice above everything else in life. Asking for help would seem to be acknowledging defeat.

By Sue Massie

**OSMA Auxiliary
President**



Auxiliary Page

These are simple illustrations of the frustrations that can enter the life of a practicing physician when a malpractice suit becomes a reality. Though there has been a slight decrease in the number of malpractice suits being filed lately, the size of awards by juries and settlements is growing at an alarming rate, according to medical malpractice insurers.

Medical malpractice suits have become a routine part of life for the medical community, but the devastation is never routine. The damage that the malpractice suit can bring to the physician, to his or her practice, and to the interpersonal relationships within and without the physician's family is indescribable.

Dr. Devany has proposed that

support groups be formed at the county level, and has asked for the Auxiliary's help in their formation. We are happy to be involved, and have asked each auxiliary at the county level to request a joint meeting with the county medical society, at which time they could view the video on malpractice available from PICO. This would be a good basis from which to start discussion regarding forming support groups in the counties. If your auxiliary does not approach you, please take the initiative to invite your spouse to join you for a meeting at which time you can discuss this issue.

Perhaps you will decide to approach this malpractice dilemma from the standpoint of general education for all, or maybe you

will want to address specific problem areas. Whatever your needs might be, I urge you to include some education on the trauma caused by malpractice suits. Together we can alleviate the stigma that accompanies this encroachment on the rights of physicians to practice quality medicine.

In the July 1990 issue of *OHIO Medicine*, I discussed the benefits of organizations working together for a common goal. Nothing could reap greater rewards than medical societies and medical auxiliaries joining forces and alleviating stress and strain from medical malpractice and from interpersonal relationships by having a support system. Together we can make a difference. Let's do it! **OSMA**



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Of Lawyers And Litigation

WHERE DOES THE BLAME LAY?

I am honored to have the privilege of writing your guest column this month. For those of you who know me personally, you will recognize that much of my career has been devoted to defending physicians and hospitals in professional negligence litigation. In this article, however, I am proud to wear the hat of the president of the Ohio State Bar Association. On behalf of the

23,000 lawyers who voluntarily belong to our association, I bring you greetings.

During my 25 years of practice, I have observed the relationships between lawyers and physicians

deteriorate. Probably the basic cause for the deterioration has been the increased number of lawsuits that are being filed against physicians and hospitals. In the early 1970s, there were only a few attorneys who concentrated their

practice on the defense of physicians and hospitals or the representation of the patients who were making claims. Today, there are numerous law firms in each of our metropolitan areas that dedicate much or all of their entire practices to such medical cases. As president of the bar, I will probably not surprise many of you by stating that I believe it is unfair to blame the increase in medical malpractice litigation on lawyers. Obviously, lawyers are involved on both sides of the cases, and the judge is also a lawyer. To blame their participation as being the cause of the suit is no more logical than to blame surgeries on the surgeon. The clients and the patients bring their problems and illnesses to us; the lawyers and doctors do not create the problems.

Doctors and hospitals should not be blamed for the increase in this litigation, either. While they are the targets of the litigation, the increased number of lawsuits filed does not reflect a decline in the quality of medical care being given to individuals. Many lawsuits against doctors and hospitals, just as lawsuits against other parties in our society, should never have been filed. Others are so meritorious that an impartial observer wonders why the matter was not resolved by the parties before suit was filed. The largest number of cases fall somewhere in between these two extremes, and these are the most difficult to resolve.

**By Gerald L.
Draper, JD**

**President of the
Ohio State Bar
Association**



Guest Editorial

What is responsible for the plethora of litigation that has involved the medical profession for the past decade? Perhaps one reason is the layman's expectation that medical science is a precise science rather than a performed art. As medical technology advances, and as the public becomes aware of the latest cures and surgical techniques, most people now expect that every diagnosis will be 100% accurate, and that, once made, the doctors will be capable of curing and treating the disease. Bad results, coupled with extremely high medical and hospital bills, drive patients, or their survivors, to attorneys to seek a legal remedy for their problems. The general public also believes that if something goes wrong in their lives, someone should compensate them for their problems.

Once the patient is in the lawyer's office, that lawyer will fulfill his responsibilities to the client by exploring all possible ways of recovery. The key element will not necessarily be whether the attorney who reviews the case feels that there may be a meritorious claim, but it is whether the attorney can find a medical expert witness who will provide all the ammunition and theories needed to develop the basis for a claim. Since more and more physicians are willing, in fact many are eager, to testify against their colleagues, it is no longer difficult for a plaintiff to find an expert witness to support the claim.

With an expert witness, the plaintiff can create a question of fact as to whether the standard of care had been met by the defendant. Under our laws, questions of fact, including the conflicting opinions held by two different experts, are jury issues. This, of course, is what a plaintiff's attorney is striving to

accomplish — the submission of the case to the jury. Without such expert testimony to establish the theory of negligence, the case would be dismissed by the judge and the jury would not be permitted to return a verdict. With it, the jury will decide whether the standard of care was met, and, if not, what damages were caused by the failure.

In addition to public expectations of successful treatment and the wider availability of expert witnesses to testify for plaintiffs, the news of high verdicts in other cases also encourages lawsuits. The dismissal of the case against a physician or hospital by pretrial settlement, summary judgment or a directed verdict during trial is rarely reported by the news media, but a verdict in favor of a plaintiff against a health-care provider always is. The larger the verdict, the closer to the front page the story moves. In a world where multi-million dollar lottery winners are announced weekly, and where multi-million dollar verdicts are announced almost as frequently, it is not all that surprising that juries who hear, at the trial, economic projections of a plaintiff's future loss which total in the millions of dollars will not be reluctant to return a verdict in six or seven figures.

As you observe the litigation process, any adverse feelings you have had toward the legal profession will probably intensify. You are offended that a physician's professional judgment has been called into question. Since the attorney's signature appears on the complaint, you blame that individual as the person responsible, rather than the patient who is the basis of the claim. The defense attorney is usually treated with more favor, but as soon as your attorney suggests that

settlement needs to be considered — or that the judge has requested the parties to attend a settlement conference, or, more significantly, he or she definitely recommends that your particular case be settled — you may feel that your own attorney is not on your side either. While this might be a normal human reaction to the concept of "giving in" or "surrendering" through settlement, sometimes the best advice you can receive is that your claim should be settled without trial.

The recent requirements that all malpractice settlements or judgments be reported to the state medical board and NPDB could, in my opinion, result in files being built up against too many of you in an unfair manner. Many competent, capable and conscientious physicians have been named in malpractice lawsuits, and settlements have been made to dismiss those claims against them. The settlements did not constitute admissions that they had made a mistake, but instead were agreed to after conducting a risk-benefit analysis that resulted in a conclusion by the physician, his or her attorney and his or her insurance company that the benefits of settling the claim and closing the file were higher than the risk of presenting the issues to a jury for decision. Physicians who are involved in high-risk areas (and accordingly a high insurance premium classification) of medical practice are especially vulnerable to lawsuits.

Under the new federal statute, physicians would be ill advised to authorize any settlement. Every settlement, even those for nuisance amounts, must be reported to the National Practitioner Data Bank. The state medical board has the authority to investigate these reports filed with the NPDB with the threat of license revocation

Guest Editorial

being omnipresent. Instead, virtually all malpractice cases will now go to a jury for decision. This means that bad cases, as well as good defense cases, will be tried to a jury. As more and more malpractice cases are presented to juries, the chances of more and more adverse verdicts against physicians and hospitals increase. As the verdicts increase in frequency and amount the publicity of those verdicts also becomes more widely disseminated. Similarly, the court dockets will become even slower as more and more cases wait for trial. The opportunities to control adverse verdicts, high costs, bad publicity and court dockets will be lost.

Many members of the legal profession, and many others in our society, including physicians, are interested in the further development of alternative dispute resolution as a partial substitute for jury trials. What must be remembered is that the negotiated settlement of a dispute before trial is the oldest, and probably most successful, form of alternative dispute resolution available today. The results are reached as a result of negotiation and compromise, and the release and dismissal of the lawsuit act as final and complete resolution of the dispute. The process also permits the parties to the dispute to resolve it, rather than giving it to a third-party stranger. Those in the best position to analyze the risks and benefits of the case are the ones who control and conduct the negotiation process. Any statute or regulation that essentially prohibits or discourages defendants from entering into such settlement process in any given claim has the serious potential of increasing the expenses of defending malpractice claims, increasing the risks of adverse jury verdicts, and removing from the parties to the dispute the

ultimate controls to the resolution process that they should possess.

Obviously, not every case should be settled, but, by like token, not every case should be tried. *All cases have some settlement value.* In some it may be a very low dollar amount, and in others it may be substantial. As lawyers and judges struggle with ways to eliminate court congestion and the reduction in the costs and time spent in litigation, the medical and legal professions need to work cooperatively to find solutions to our common problems. We should be seeking ways to expedite the resolution of disputes rather than prolonging the battles. The notion that the elimination of settlements

will reduce the number of cases filed is a *non sequitur*. It would be great if it worked that way, but I am afraid that past experiences in other similar endeavors have never proved successful. The professions need to put their particular differences of opinion to one side long enough to seek methods and procedures that will be fair to physicians and to those who are injured by professional negligence. The role played by each of our professions in our society needs to be accepted and understood by the other. On behalf of the lawyers of Ohio, I would urge our members and committees to work closely with you in developing those solutions. **OSMA**



Sources for Clinical Clips

Elderly alcoholics	<i>The Cleveland Plain Dealer</i> , July 22, 1990
Depression	<i>Dayton Daily News</i> , Dec. 6, 1990
Melanoma cases	<i>Toledo Blade</i> , July 24, 1990
Passive smoke	<i>Dayton Daily News</i> , Jan. 10, 1991
Women smokers	<i>Beavercreek News</i> , Jan. 11, 1991

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ADVERTISING'S DECEPTIVE TRUTHS

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As the First Amendment has been interpreted, any person can state, in any medium of their

choice, any false, misleading, or deceptive health information they choose. The law can only be broken if the false information is on the label of a product or the fraud occurs in the

course of a provable doctor-patient relationship. The system utilized by the FDA, FTC and FCC depends on warnings or complaints from the public, who rarely know they are being misinformed and thus cannot complain. The

“Genericgate” scandal of 1989, exposed by Rep. John D. Dingell (D-Michigan), has not yet been resolved, and it continues to suffer from new disclosures, which not only involve the industry but also the FDA. “Natural remedies,” which line the shelves of health food stores, sound innocent enough, and those who take them never dream they could be harmed until L-Tryptophan left 19 people dead and countless others ill. Most recently, a “new” egg, touted as having no effect on cholesterol levels, has been test-marketed in southern Ohio and other areas of the country. The FDA has challenged the validity of the cholesterol claims, and its safety has been impugned because the eggs contain too much iodine, which comes from the “secret low-fat” chicken feed. Despite the challenge, the product remains available, and the marketing blitz goes on. If this is the mechanism (FDA, FTC, FCC) on which we are to rely, then we, as advocates for our patients, must enlist the help of our legislators to change and strengthen the laws, enhance the budgets and improve the warning systems upon which the agencies depend. In addition, we must inform our patients of associated dangers inherent in some medications, natural remedies and food. Lastly, the media should assume greater responsibility in developing procedures to screen our misleading advertisements. **OSMA**

By William J.
Marshall, MD





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The Medical Salad

HOLD THE "LEAVES"
AND HOLD THE "VEGGIES"

By Edmond Gardner,
MD

Being a gourmet cook, I approach most issues from a gustatory point of view. Medical societies are closely related to a salad in their makeup. Most salads start with the leaves of lettuce necessary to make the body of the salad. In medicine, we follow the same recipe. However, we have many kinds of leaves:

leave it to the other guy, leave me alone, leave me out of it, leave it alone, etc.

This resounding pile of "leaves" is then covered with the oil or dressing, which holds the salad together. The medical salad has its leaves held together by the

mutual bonding of needs, which acts as the glue to make the medical salad work as a cohesive unit to address issues. No salad would be complete without the "veggies," and neither would the medical salad. Most societies and organizations are composed of the 10% who are the motivators,

movers and shakers, the 10% who never do anything, and the 80% who are willing to help occasionally, but usually do not have the motivation to get involved on their own. The medical salad has its 10% of veggies, i.e. those who continue to vegetate and do nothing for organized medicine, yet are quite able to criticize when decisions are made.

No good salad could get by without the condiments, which give that extra special flavor. These are sprinkled on top to provide flare. At the top of the medical salad, we have the officers, leaders and committee chairpersons who combine their efforts to provide that special flair to make a society successful.

No single part of the medical salad would be successful without the rest of the ingredients. Ultimately, organized medicine would like to see more of the condiments and salad dressings to make a good salad, and less of the leaves and veggies, which add body, but little flavor.

Although this is written as a tongue in cheek article, perhaps some of you will see yourselves as a part of the medical salad. For those who fit the part of veggies and leaves, I would sincerely hope you see the need for involvement. Your various societies are only an instrument to provide a mechanism to get the job done. The societies do not do the job. It is the membership that must get involved

Continued on page 219



Letters to the Editor

References added to epilepsy report

To the Editor:

On behalf of the Epilepsy Standards Subcommittee of the Bureau for Children with Medical Handicaps, I would like to thank you for printing the special report, "Recent Developments in the Management of Epileptic Seizures" and "Minimum Care Standards for Epilepsy for Ohio" in the November 1990 issue of *OHIO Medicine*.

It has been noted that there were four errors by the author in references on the original manuscript. It would be appreciated if you would print the following corrections:

Appendix E:

Epilepsy Association of Central Ohio

115 West Main Street, Suite 300
Columbus, Ohio 43215
(614) 228-4401

Epilepsy Association of Western Ohio

49 Park Avenue, Suite Three
Dayton, Ohio 45419
(513) 298-3501

Epilepsy Services Network of Ohio
1355 Dublin Road, Suite 126-D
Columbus, Ohio 43215
(614) 488-0185

Appendix F:

The specialty of G. Dean Timmons, MD, is pediatric neurology

James F. Quilty, Jr., MD, Chief
Bureau for Children with Medical Handicaps
Division of Maternal and Child Health
Ohio Department of Health
Columbus



Confusion over rural MD shortage

To the Editor:

I recently read an article in the January 1991 issue of your magazine entitled "Rural Areas Losing Appeal for Young Doctors," and I must admit I'm a little confused. I am a second-year medical student at the University of Cincinnati, and am myself from a small, rural community in southern Ohio. Frankfort, Ohio has a population of about 1,000 and I feel it was a wonderful place to live and grow up.

The reason I'm confused is that, including the year I sat out between undergraduate and medical school, I have been looking for an opportunity for the last three years to work something out, so I may practice in a rural setting. I would like to stay in Ohio, and I would be glad to serve any community, county, hospital or state agency that would help me get through this financial nightmare we refer to as medical school. I have been offered opportunities with the armed forces and recently with the National Health Service, but I would much prefer an Ohio-based

guarantee, somewhere I wouldn't have to serve for two, three or four years, but could work on setting up a permanent practice.

During my senior year at Denison University and my year off following that, I contacted numerous municipal, county, hospital and even state agencies, but to no avail.

Rural doctors are on the decrease. However, given the right effort by both the people who need the doctors, and those who want to help put us there, this situation could be completely reversed.

Sincerely,

Todd L. Seyfang
Cincinnati

Corrections

February's article on "Physician Advertising, Then and Now," identified Charles A. Peter, MD, as a Toledo physician. Dr. Peter is from Akron, not from Toledo.

In the article on "Substance Abuse Education," written by Jane Uva, Margaret Bean-Bayog, MD is identified as an instructor at the Wright State University School of Medicine. Dr. Bean-Bayog is a faculty member at an out-of-state school, and not associated with Wright State, a fact that the author mentioned in a citation that was inadvertently omitted.

OHIO Medicine regrets these errors.

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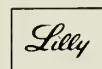
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Ohio Medi-Scene

Hospital recruitment adds twist

The next time you go to the movies, you may see more than a plug for coming attractions. Two hospitals in Columbus — Saint Anthony Medical Center and Saint Anthony Mercy — have been showing recruitment slides at theaters to promote careers in health care.

According to Steve Hedlun, director of personnel, an estimated 250,000 people will view the slides, an important fact when one considers that, according to the American Hospital Association, shortages are growing worse for 16 hospital occupations.

"If it requires schooling and it's in health care, everybody's fighting for them," says Hedlun. "It's a tough area — it's everybody's priority."

But while St. Anthony's efforts may be unique, they are certainly not the only ones being made. In the Columbus area, at least, Mount Carmel Medical Center has been practicing proactive recruiting, or hiring someone before a position becomes open; Ohio State University Hospitals has formed a group to study the effect scholarships and sign-on bonuses have on recruitment; and Children's Hospital is using an Explorer post to expose children to the field of health care. **OSMA**

Lawmakers learn there's no quick fix to health-care woes

State lawmakers who attended a conference on health-care financing and access problems held earlier this year in Columbus learned that there is no quick and easy solution on the horizon.



However, the problems are not likely to be solved by adopting a Canadian-type, tax-paid health-care arrangement for all citizens, conference speakers warned.

The conference, organized by major state business groups, including the Ohio Chamber of Commerce, Ohio Council of Retail Merchants and the Ohio Manufacturers' Association, explored alternatives to state-funded universal health care.

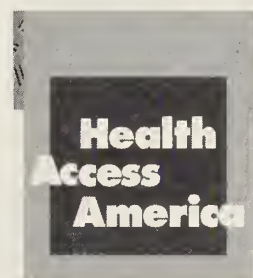
Although speakers from across the nation differed widely on how to achieve universal coverage, who should pay for it, and how to bring down skyrocketing medical costs, an emerging theme seemed to be that the existing system need not be scrapped in order to extend health care coverage to the estimated 37 million Americans without health insurance.

Recommendations for achieving the goal of universal health coverage included expanding state and federal Medicaid and Medicare programs to cover a larger number of poor people.

An AMA board member who also spoke at the conference

suggested that the AMA's 16-point Health Access America proposal may also accomplish the goal of universal health within the existing system. Health Access America calls for public and private sector reforms to improve health-care access and was endorsed by the OSMA at the 1990 Annual Meeting.

Legislation was recently re-introduced in Ohio to establish a Canadian-style universal health-care system in the state. The OSMA strongly opposes this legislation. **OSMA**



Ohio Medi-Scene

Economic woes pitch farmers into depressions

Ohio's countryside may not be quite as bucolic as it looks. According to surveys done in other Midwest communities, the rate of clinical depression among farm families rose from 10.7% to 21.4% between 1981 and 1986.

"There are signs of continuing deterioration," says Joan Blundall, director of consultation and education for the Northwest Iowa Mental Health Center. "The people we're seeing feel like they're in captivity. They can't get away. It's chronic, unremitting stress."

Although the mid-1980s "farm crisis" is supposedly over, the Agriculture Department recently reported farm county per capita income in 1988 was 75.9% of the national average and in the first three months of 1990, rural unemployment and underemployment stood at 10% of the population, 2.6 points higher than in urban areas.

In addition to the rising statistics for clinical depression, a University of Minnesota study shows that 3% of rural adolescents in that state had attempted suicide the previous month. The Oklahoma Council of Churches has also reported that nearly two and a half times the number of farmers sought treatment for alcoholism as had the previous year. Economic hardship was believed to be the trigger. **OSMA**

Lyme disease in Ohio?

Clark County claims that four cases of Ohio-acquired Lyme disease have surfaced there recently, but Ellen Peterson, an epidemiology investigator with the

Ohio Department of Health, isn't so sure.

"Something is going on there, but we're not certain that it's Lyme disease," she says.

According to news reports, four Medway residents have complained of symptoms similar to those that frequently distinguish Lyme disease. All four live near each other, and their travel histories show no indication that the disease could have been transmitted by out-of-state deer ticks.

Peterson, however, says there is no indication that the deer tick is established in Ohio.

"We did find two additional specimens of deer tick on Ohio deer last November," she says. "That's the second and third species of deer tick we've discovered in Ohio."

The first deer tick was found in June 1989 on a deer carcass in Butler County. The two deer tick species discovered in November were found in Clermont and Williams counties. No deer tick have been found, so far, in Clark County, however Peterson says the ODH will continue to closely monitor the situation. **OSMA**



Ohio Medi-Scene

Colleagues

Michael Maloney, MD, Cincinnati, director of psychiatry and psychology at Children's Hospital Medical Center, has been awarded the 1990 Simon Wile Award from the American Academy of Child and Adolescent Psychiatry for his contributions to pediatric consultation on a local and national level. Dr. Maloney teaches pediatric residents, faculty and pediatricians as well as medical student and child psychiatry fellows.

Wilma Bergfeld, MD, Cleveland, was elected president-elect of the American Academy of Dermatology at its recent meeting.



Bergfeld

Antoinette Parisi Eaton, MD, Columbus, became the first woman to assume the presidency of the American Academy of Pediatrics in the organization's 60-year history. Dr. Eaton is corporate director of Governmental Affairs at Children's Hospital, Inc.

Froncie A. Gutman, MD, chair of the department of ophthalmology at the Cleveland Clinic Foundation, was elected president-elect of the American Academy of Ophthalmology.

In addition to his Academy post, Dr. Gutman is a member and past chair of the American Board of Ophthalmology. He is a member of the Boards of Trustees of the Association of University Professors in Ophthalmology and the Cleveland Society for the Blind, associate editor of the *Journal of Ophthalmic Surgery* and a member of the Pan American Association of Ophthalmology's Board of Directors. **OSMA**

Clinical Clips

560,000 to 2.8 million

Number of Americans over 65 years old who are alcoholics

7 million

Number of American women suffering from depression

30,000

Number of suicides a year attributed to depression

1 out of 8

Number of men who suffer from depression during lifetime

25%

Number of women who suffer

27,600

Number of U.S. melanoma cases in 1989

6,000

Estimated death toll from melanoma in 1990



53,000

Number of Americans killed by passive cigarette smoke yearly

30%

Percentage of people living with smokers who are likely to suffer from heart disease or heart attacks

27%

Number of women smokers in Ohio in 1988 compared to 25% of the males

More than half

Number of women who start smoking before 10th grade

25% to 50%

Percentage of fetal and infant deaths related to smoking

Sources on Page 165

Should You Accept Gifts From Industry?

THE AMA'S GUIDELINES

There has been growing concern about the potential negative consequences of the relationship between the medical community and industry. In

particular, the appropriateness of some of the gifts given to physicians by companies in the pharmaceutical, device and medical equipment industries have been questioned. This report

discusses the ethical issues raised by the practice of industry gift-giving and proposes guidelines for physicians to distinguish appropriate from inappropriate gifts.

Ethical concerns

The practice of gift-giving raises a number of ethical concerns.

1. Influence on physician practices. Industry invests in

promotional activities because promotions increase sales. As one commentator has observed, no company "gives away its shareholders' money in an act of disinterested generosity." There is no evidence that physicians knowingly or intentionally compromise their patients' care as a result of gifts from industry. Nevertheless, the practice of gift-giving may mobilize subtle influences that can result in practice patterns based on considerations that go beyond scientific knowledge and patient needs.

2. Appearance of impropriety. Even when gifts from industry have no effect on a physician's practices, there may be a public impression of impropriety, especially if the gifts are of substantial value. The trust of the public that physicians are dedicated foremost to the welfare of their patients may be undermined when there is a possibility that the choice of a drug, device or other product is influenced by the fact that the physician had received a gift from the company that manufactures the product. For example, when companies schedule their own conferences at resorts and pay for physicians and their spouses to attend for a weekend that includes only a few hours of lectures and many hours of recreation, lavish meals and expensive entertainment,



Ethics

it is difficult to view the conference as serving a legitimate educational purpose.

3. Cost of gifts. The costs of gifts from industry to physicians are ultimately passed on to the public. In effect, then, patients may be paying for a benefit that in some cases is captured primarily by their physicians. Physicians should not accept inappropriate gifts, because the cost is ultimately subsidized by patients.

The Council on Ethical and Judicial Affairs recognizes that many gifts from industry to physicians result in significant benefits to patients. For example, books and conferences contribute to the education of physicians, and meals at medical meetings or conferences provide a forum for colleagues to exchange information. These kinds of gifts can therefore be appropriate, depending on the extent to which the gift serves a function beneficial to patient care and on whether the same benefits can be realized through less costly promotional activities.

Guidelines for Gifts From Industry to Physicians

The ethical considerations discussed above suggest several principles.

1. Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals and other gifts are appropriate if they serve a genuine educational function. On the other hand, cash payments serve only the physician's personal interest and therefore should not be accepted from industry.

A gift that is appropriate because of its contribution to patient care may become inappropriate because of its extravagance.

Continued on next page



Pharmaceutical board adopts AMA guidelines

The Pharmaceutical Manufacturers Association (PMA) late last year voted to adopt the AMA's new ethical guidelines for physicians. The AMA House of Delegates adopted the new guidelines December 4, and the PMA adopted them two days later.

The guidelines, in part, state that:

- Physicians should not accept reimbursement for costs incurred when attending meetings or conferences from industry sponsors.
- Special funds that allow

medical students, residents and fellows to attend such conferences are permissible.

- Physicians should not accept gifts if there are strings attached (e.g. accepting a gift in return for prescribing a certain drug).
- Physicians may accept gifts if they serve an educational function (e.g. textbooks).

The PMA is a nonprofit, scientific and professional organization of more than 100 companies that develop and produce prescription drugs in the U.S. **OSMA**

Ethics

Gifts of minimal value raise fewer concerns and are permissible as long as the gifts are related to the doctor's work (e.g., pens, diaries, books or rulers).

2. Gifts by drug companies to underwrite medical conferences or other professional meetings enhance the ability of academic institutions, professional associations and health-care organizations to provide continuing education to physicians. Consequently, such gifts make an important contribution to patient care. Subsidies from industry should not be accepted to pay for the costs of travel, lodging or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physicians' time. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of a conference or meeting.

It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging and meal expenses. Token consulting or advisory arrangements cannot be used to justify compensating physicians for their time or their travel, lodging and other out-of-pocket expenses.

The giving of a gift directly to a physician from a company's sales representative may create a personal relationship that could influence the use of the company's products. Accordingly, when a company contributes funds for conferences that are sponsored by academic or other educational

institutions, the funds should be given by the company to the conference sponsor who in turn can use the money to reduce the conference's registration fee. Payments to defray the costs of a conference should not be accepted directly from the company by the

Guidelines for gifts

- 1) Any gift accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value.**
- 2) Gifts by drug companies to underwrite medical conferences or other professional meetings are fine.**
- 3) No gifts should be accepted if there are strings attached.**
- 4) Sponsors of continuing medical education conferences must ensure that gifts are appropriate.**
- 5) Financial support for conferences should be disclosed publicly.**

physicians attending the conference.

3. No gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician's prescribing practices.

4. Sponsors of continuing medical education conferences have a special responsibility to ensure that gifts are appropriate. The Accreditation Council for Continuing Medical Education has adopted a number of useful guidelines to prevent industry funding for continuing medical education conferences from leading to undue influence by the companies; (a) responsibility for and control over the selection of content, faculty, educational methods and materials should belong to the accredited sponsors of conferences, (b) presentations must give a balanced view of all therapeutic options, and (c) financial support must be acknowledged in printed announcements and brochures, but reference should not be made to specific products.

The Task Force on Pharmaceutical Industry/CME Cooperation is currently developing an updated set of guidelines for industry funding of continuing medical education conferences.

Some of these guidelines are appropriate for smaller educational meetings and in other educational contexts, for example, when companies support meetings or lectures for medical trainees.

5. Financial support for conferences should be disclosed publicly. Physicians will be able to evaluate the information presented to them more appropriately if they are aware that companies have contributed funds to defray the costs of the presentation. **OSMA**

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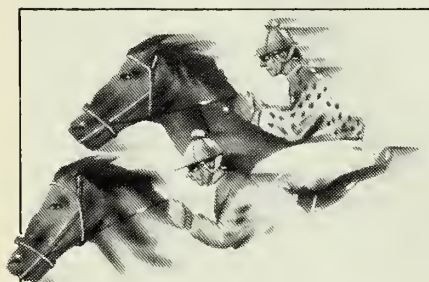
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Marketing . . . continued

rule is "Keep it simple." Says one expert: "There's no doubt that newsletters strengthen the bond between you and your patients, but there's no need for you to look like you're trying too hard to do that . . . people don't like the image that a too-flashy production creates. They figure if the doctor has to spend a lot of money getting the word out about his practice, there's something wrong with it."



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Experiences in China

A WESTERN MD

GOES EAST

By James G. Ravin, MD

The temperature was at least 95°, with 95% humidity, in an operating room of the First Affiliated Hospital at Wenzhou in July. The overhead lights increased the heat as did the 25 or 30 observers who milled in and out. They nudged the operating table and my elbows while muttering softly. The doors creaked open and closed as each

entered or left the small room. I would have appreciated a stronger light source for the operating microscope. In addition, the intensity of electric power in China can be variable, making visibility a challenge. The optics, at least, were good in the Chinese copy of a

Zeiss microscope. I prayed that the power would not go out as it had 10 minutes into a case the previous day at Second Affiliated Hospital. I asked for drugs and instruments that, unfortunately, did not exist in eastern China. My command of the Chinese language is extremely

limited, at best. Their English, although much better than my Chinese, left quite a bit to be desired, making communication difficult.

We did have lidocaine with epinephrine for anesthesia. Fortunately, the patient did not feel pain, or at least was able to hold himself still. Would the effect have been the same if acupuncture had been the sole anesthetic, I wondered? We had scrubbed the required 10 minutes and soaked our hands and arms in alcohol for several minutes more, prior to donning cotton operating gowns and resterilized rubber gloves. It was strange to wear Chinese boxer shorts as part of a surgical outfit.

I had not planned on operating at the First Affiliated that day. Instead, I was prepared to lecture on how cataract surgery is done in America, but the chair of the department preferred that I perform a few cases so they could observe my technique. Few of their people have a good working knowledge of English. No truly fluent translator was available to accompany me, unlike the situation in several other Chinese hospitals I had visited. As is often the case in China, they presented me with several complicated cases, and requested that I perform surgery on a few of these patients.

The first patient selected had a mature cataract and severe glaucoma. I did a combined cataract extraction with intraocular



International Health

lens insertion and trabeculectomy. The sweat poured down my forehead and through the gown in the hot operating room as the complexity of the procedure under difficult circumstances became more and more apparent. I had left a supply of intraocular lenses and viscoelastic agents at another hospital. I asked that these things be sent over, but only a few intraocular lenses arrived. Without my usual instruments, I was forced to rely on theirs, which were of good quality, although not what I was used to using. Fortunately, removal of the nucleus was accomplished without difficulty. Cortical clean up under low levels of illumination was a challenge, but was completed successfully. Inserting an intraocular lens was more difficult. The donated lenses I had brought were not styles I was accustomed to using, and no viscoelastic agent was available. Eventually the implant was positioned within the capsular bag and the trabeculectomy was completed. Less sweat poured through my gown as the conjunctiva was closed. In the changing room we discussed surgical technique. "What was the key moment in the surgery?" I was asked. I could only reply that to me each step depends on the one before, and steps taken in unfamiliar territory are more difficult than in one's usual environment.

Was the surgical experience worth the trouble? Certainly. To test one's self under difficult circumstances, and to end with a good result, is certainly fulfilling. The Chinese surgeons reinforced my feelings by saying they learned from the endeavor. I gained the experience of working with colleagues on their turf.

On hospital rounds I saw patients who had undergone corneal transplantation, cataract



Dr. Miao and Dr. Ravin in Wenzhou, China.

surgery, muscle surgery, and repair of traumatic wounds. Injuries in the work place and vehicular accidents are common in China. I witnessed several traffic accidents on Chinese roads involving cars, trucks and bicycles. In one bicycle accident, a child bounced into a loose 220 volt wire, and was severely jolted. Fortunately, she suffered nothing more than a severe scare. Cataract is the most common ocular problem in China. More than one million Chinese are blind from cataracts. Lens opacities are most prevalent in Tibet and in southern China. In both these areas ultraviolet light exposure levels are high. Glaucoma is common, with angle closure occurring more frequently than in America. Narrow angle glaucoma is encountered about as often as open angle glaucoma. Many acute angle closure glaucoma patients are first designated in emergency rooms, complaining of nausea, vomiting and eye pain. Corneas

for transplantation are not easy to acquire in China, since many families are not willing to donate the cornea of a recently deceased relative. Executed convicts are often the source of donor material.

The Chinese physicians I met were knowledgeable, full of interest and quick to learn. As in many developing countries, Chinese doctors and hospitals suffer from financial constraints. Much of the equipment we are accustomed to in the West is not available in China. As a result, Chinese doctors become good at improvisation. CT scanning is available even in the smaller cities. The radiologic studies we saw were of good quality. All studies were done in the radiology department, none done by portable units on the wards. To save on costs, fluoroscopy is often performed without developing film. Consequently, the clinician and radiologist observe the fluoroscopy together. Ultrasound is available.

International Health

Visits by families to their relatives in the hospital is tightly controlled. We were told that one family member is asked to be present at all times to help care for the patient and for contact with the nurses and physicians. Only that member is allowed on the ward.

We had been warned to be careful in conversations with Chinese people since this could cause them (but not us) difficulties. They might be interrogated should they chat with a Westerner. We found this not to be a problem. Many Chinese were most happy to initiate conversations with us. Some divulged their opinions on controversial topics such as religion and politics.

Those old enough to have experienced the Cultural Revolution of 1966-76 had unique and fascinating stories to tell. Physicians, because of their education and status, were often singled out for harsh treatment at that time. Those with a religious background, especially a Western religion, were often treated roughly. One surgeon told me his episode of house arrest in a hospital, with communication to friends and family cut off. Another described being sent into the countryside for several years, to toil in the fields. Many were beaten. Medical care was drastically affected by the Cultural Revolution. Party loyalty was a prerequisite to continue to practice medicine. Western medicine was deprecated. Many surgeons were forced to use acupuncture for anesthesia, as a test of party loyalty. Medical schools were closed. Untrained individuals practiced medicine and even surgery. They followed chairman Mao's diction of "learning by doing" literally.

"The Influence of Mao Tse-tung's Thinking Upon My Practice

of Ophthalmology" was the lead article in the *Chinese Medical Journal* of May 1966, at the beginning of the Cultural Revolution. The author described himself as a member of the "exploring class," and that he needed "ideological remolding and increased political consciousness" in order to work properly.

The Chinese understand that advancement in many areas, including medicine, is facilitated by a working knowledge of the English language. Many of them attend English language institutes and listen to English language broadcasts on shortwave radios. *Reader's Digest*, *Time* and *Newsweek* are popular magazines. They would initiate conversations in English to practice what they had learned. I was often a curiosity, one of those pale-skinned Westerners with hairy arms. Crowds often would congregate to see the foreigners

and listen to English spoken. Some astute Chinese would even act the part of Henry Higgins, in an attempt to localize my accent to a particular part of the U.S.

American expressions have become popular in China. Shirts and pants are no longer the monotonous Mao blue or green uniform. Instead, shirts and blouses may say "Texas Style" or "He-Man" and have a California beach scene emblazoned on the front. Popular music shows an American influence. Along the tree-lined pedestrian thoroughfare of Shanghai's waterfront, "The East is Red" is no longer played. Instead, "Three Coins in the Fountain" emanates from loudspeakers, and water spurts from fountains in time to the music. New Orleans jazz is a popular attraction.

Several Chinese students asked me about American colleges. Many
continued on page 186



Dr. Ravin with lab technicians at Beijing University Medical School.

Eponyms . . . continued

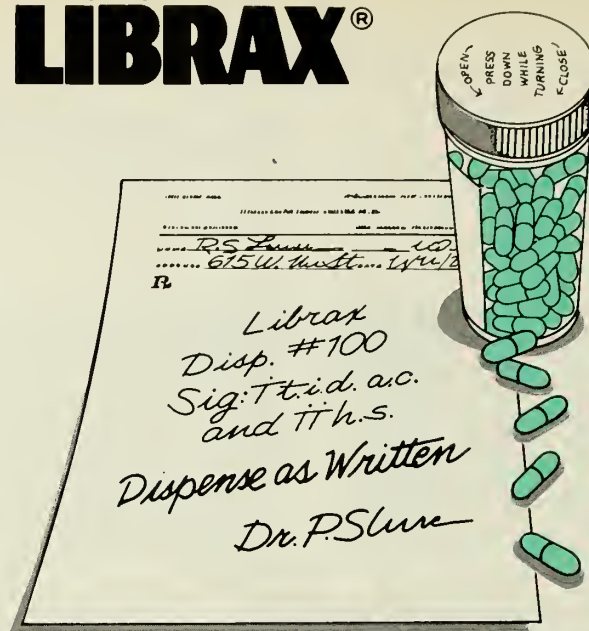
mythology are males and all patients with the syndrome have been females except one,⁹ whose features, however, were not quite those of the syndrome.³ **OSMA**

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Revised: February 1988



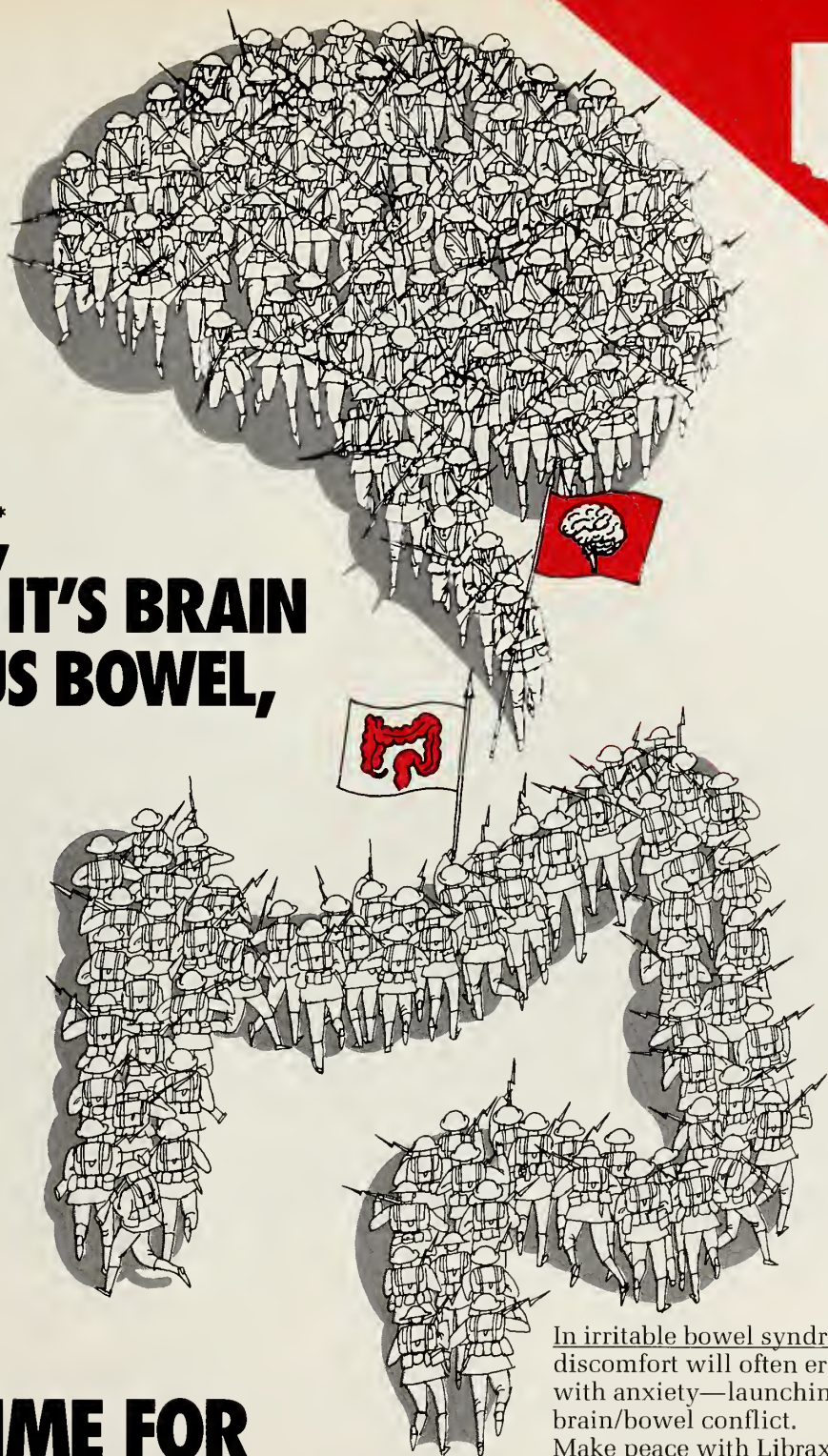
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Please see summary of prescribing information on adjacent page.

International Health

young men and women said they can obtain funds to visit America and can get permission to study at American universities, if there can be some way to obtain a scholarship. Some would like to work while attending an American school. Many Chinese students have heard that physicians and lawyers live affluent lives in America. They had difficulty understanding that a teacher might have to economize in our rich country. When asked what job they would most prefer to have in China, many said they would like to be a taxi driver, since taxi drivers do very well financially.

In the midst of the world's most populous country, one cannot avoid feeling the mass of humanity. It is fortunate that very few automobiles are in private hands and that the bicycle is still the main method of transportation within China. If most Chinese people could afford an automobile, the roads would be hopelessly congested and the pollution would be even worse. Bicycles are used to transport everything from animals to huge piles of hay. On a Sunday ride, a husband may peddle along, with his wife riding sidesaddle over the rear wheel and a child over the handlebars.

Feeling the pressure of thousands of people trying to exit the main railroad station in Shanghai, or trying to cross a street in Beijing against the flow of hundreds of bicycles, it is easy to understand China's population problem. The numbers of people on the streets and packed into buses are overwhelming. China's 1.1 billion people constitute 20% of the world's population and, at times, they all seem to be going down the street together.

The one-child-per-family policy was instituted in 1980. The policy encourages people to not marry until they are in their 20s, at least.

China has made great strides since its liberation in 1949. The life expectancy has doubled from 35 to over 70 years of age. Extreme poverty, prostitution, drug addiction and many infectious diseases have been eliminated.

"Chinese couples should refrain from having more than one child for the good of the entire nation," says the authoritative Chinese publication *Health News*. People of Han descent, who make up 94% of the Chinese population, are strongly encouraged not to have more than one child. Ethnic minorities are not dissuaded from having two or three children. Financial disincentives can be great hardships to families having more than one child. Even with the one-child policy, the population is still growing as births exceed deaths. Twenty million Chinese people annually reach the age of marriage and child bearing.

Paradoxically, the Chinese people are proud that China's first test tube baby was born at Beijing Medical University in 1988. She is now two years old. Newspaper articles describe her clever, healthy and sometimes mischievous nature. Although family planning is a

must in China, sterile men and women are receiving treatment to help them conceive. Several Chinese confided to me that although they understand the nation's needs, they personally are unhappy with the impact this has on their own families.

The excess of people in this developing country has caused problems in rural as well as urban areas. In summer, the air of the countryside may attack one's nose since pungent "night soil" is used for fertilizers. Many factories have moved to rural areas, and their coal-generated smoke can be noxious in the winter. But it is the 80,000 factories along China's coastline that are the greatest polluters of all. Factories along China's coast discharge five billion tons of industrial waste water daily. The muddy turbulence from polluted water may be seen as far as three hundred miles out to sea.

China has made great strides since its liberation in 1949. The life expectancy has doubled from 35 to over 70 years of age. Extreme poverty, prostitution, drug addiction and many infectious diseases have been eliminated. Everyone has a job, a home and food. The people seem to have a useful purpose — they are building a country.

To any jaded American physician, I would recommend a working visit to China. Better yet, take your teenager along. He or she will gain a better appreciation for life and for what medicine can offer. **OSMA**

1991 OSMA ANNUAL MEETING



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Candidates for the

Stanley J. Lucas, MD

A Cincinnati native Stanley J. Lucas, MD, earned his undergraduate degree from the University of Cincinnati in 1948 and stayed there to attend medical school. He received his medical degree in 1951, then interned at Cincinnati General Hospital for 1951-1952.

In 1952, Dr. Lucas started his residency at Cincinnati General Hospital, only to interrupt his training after a year for a two-year stint as a captain in the U.S. Air Force. He served at Travis Air Force Base in California, then at Elmendorf Air Force Base in Anchorage, Alaska.

Dr. Lucas returned to Cincinnati General Hospital (now University Hospital) and completed his residency in radiology and was Board-certified in 1957. For four years, Dr. Lucas practiced with a senior radiologist, then entered private practice in 1961.

In addition to his private radiology practice and working with the Radiology Group at the Cincinnati Jewish Hospital, Dr. Lucas has always been actively involved at the local, state and national levels of organized medicine.

He has served as President of the Academy of Medicine of Cincinnati, President of the Radiological Society of Greater Cincinnati and Delegate (since 1987) and Alternate Delegate (1982-1987) from Ohio for the American Medical Association.

He is also a member of the Radiological Society of North America, the American College of Radiology and the Jewish Hospital medical staff, where he served as

Secretary for two years.

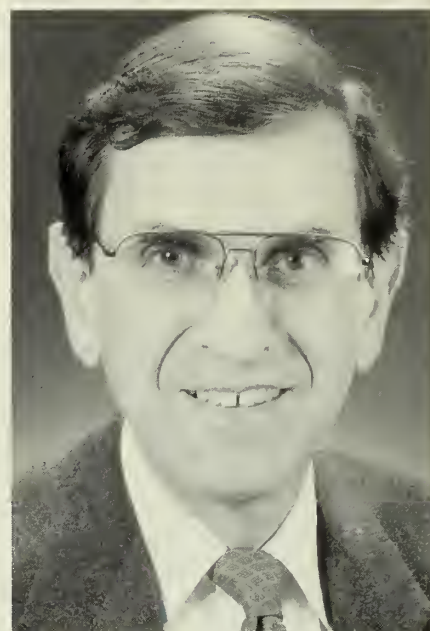
At the state level, Dr. Lucas served for five years as First District Councilor for the Ohio State Medical Association, as well as Delegate and Alternate Delegate since 1975, and has spent time on a number of other association committees, including Membership, Legislation and Health Planning Advisory. He chaired the Auditing and Appropriations Committee and several reference committees.

Dr. Lucas' interest and involvement in his profession as well as his community are reflected in numerous activities. For example, he serves as an assistant clinical professor of radiology at the University of Cincinnati, teaching senior elective radiology. He also served as a member of the Policy Development Committee and Radiology Task Force for the Central Ohio River Valley Authority.

One of Dr. Lucas' important victories occurred when he aided in the policy development of the Certificate of Need (CON) for CAT scanners, making them more readily available to hospitals. He also led the successful effort for third-party reimbursement for pre-admission testing when done in a private office.

At the community level, Dr. Lucas has served as professional division chair for United Way and as president and alumni adviser for the Cincinnati Chapter of Phi Delta Epsilon, a medical fraternity.

He has been recognized in Who's Who in the Midwest (since 1969) and Who's Who in America (since 1986). In 1985, he was honored for his efforts between the



Stanley J. Lucas, MD

Academy of Medicine and the Cincinnati Bar Association for updating the "Standards of Practice Between Lawyers and Physicians."

Dr. Lucas is an avid collector, author and exhibitor of medical history. Some of his antique tray equipment is currently on display in the Cincinnati Medical Heritage Center of the University of Cincinnati. He also enjoys the theater, symphony, opera and museums. His wife Judy is curator of the Skirball Museum, Cincinnati Branch at Hebrew Union College. Travel, bridge and poker also keep the doctor busy when he's not working.

The Lucases have three daughters and two sons. Both sons have decided to pursue medical careers; one is a practicing radiologist and the other is a second-year medical resident. **OSMA**

Office of President-Elect

Jack L. Summers, MD, PhD

Dr. Summers was born in Clarksburg, West Virginia, and completed both his undergraduate and medical studies at West Virginia University. After receiving his medical degree in 1966, he came to Akron City Hospital, where he served an internship, as well as a residency in general surgery. Following two years of service in the Navy, where Dr. Summers obtained the rank of lieutenant commander, he returned to Akron City Hospital for a residency in urology. During that time, he also completed a six-month residency in pediatric urology at Akron Children's Hospital. Dr. Summers presently has a private practice in urology in Akron. In 1988, Dr. Summers obtained a PhD in human sexuality at the institute for the Advanced Study of Human Sexuality, San Francisco, with a thesis entitled "The Effects of Multiple Sclerosis on Human Sexuality." He has also been certified as a sex educator by the American Association of Sex Educators and is Board-certified by the American Board of Sexology.

Dr. Summers has had a long and active involvement in professional associations, listing over a dozen organizations in which he holds professional membership. Among these are the American Medical Association, the OSMA, the American Board of Urology, the American Fertility Society, and the American Association of Clinical Urologists. He's an associate editor of the national urologic publication *A.U.A. Today*. While he has served on numerous committees affiliated with these organizations, he has

been an especially active member of the OSMA. He has served as a delegate to the OSMA from 1979-1982, and again from 1986-1987. In addition, he served as an alternate delegate from Ohio to the AMA from 1987-1989.

Dr. Summers' concern over the nation's AIDS epidemic has led him to a position as chair of the OSMA's AIDS Task Force Committee, as well as to other appointments on local AIDS committees.

Aware of medicine's need to become actively involved in the political arena, he is a member of the Ohio Medical Political Action Committee, and regularly helps to set OSMA policy, as District 12 Councilor.

Despite his extensive service at the state level, Dr. Summers has found time to serve in numerous positions at the local level, including a turn as President of the Summit County Medical Society in 1984. He is also an active member of his specialty societies, and has served as Vice President of the Cleveland Urological Society (1982) and President of the Ohio Urological Society (1986).

Dr. Summers is both a noted lecturer and author, and several of his scientific presentations have received professional awards.

In his leisure time, Dr. Summers enjoys creative writing, jogging and gourmet cooking, and he is a certified scuba diver. He also enjoys military history, and owns a collection of military miniatures.

Dr. Summers and his wife Patricia have two children, Scott and Marcia. **OSMA**



Jack L. Summers, MD



**Don't
Forget:**

- **The OMPAC
Dinner
7 p.m. Saturday,
May 18**
- **Hospital Medical
Staff Section
Meeting
9:30 a.m.
Friday, May 17**

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1991 House of Delegates Annual Meeting Schedule

Headquarters Hotel: Hyatt Regency Columbus at Ohio Center
350 North High Street
Columbus, Ohio (614) 463-1234

THURSDAY, MAY 16

OSMA COUNCIL MEETING

3 PM

Marion Room

FRIDAY, MAY 17

SPOUSE HOSPITALITY ROOM

8:30 PM

Champaign Room

HOSPITAL MEDICAL STAFF SECTION MEETING

9:30 AM

Franklin A & B (lunch on your own)

EMERGENCY RESOLUTIONS COMMITTEE

LUNCHEON

12 Noon

State Room A

BRIEFING SESSION FOR FIRST-TIME DELEGATES & ALTERNATES

1 PM

Franklin C

HOUSE OF DELEGATES

1-6 PM

Registration

Regency Ballroom Foyer

2:30-4:30 PM

COUNCILOR DISTRICT CAUCUSES
(posted at Registration)

5-5:45 PM

Dinner

Union A-E

6 PM

Opening Session

Regency Ballroom

AFTER HOUSE OF DELEGATES

ADJOURNMENT (approximately 8:30 PM)

Reception sponsored by the Columbus Academy of
Medicine and Physicians Health Plan, Inc.

Franklin C & D

SATURDAY, MAY 18

REFERENCE COMMITTEES

6:45 AM

Breakfast

Union A-D

7:30 AM

Registration (if you have not already registered on
Friday) Regency Ballroom Foyer

8 AM

Hearings

Committee No. 1, Delaware A & B

Committee No. 2, Delaware C & D

Committee No. 3, Franklin A & B

Committee No. 4, Franklin C & D

Nominations Committee, Board Room 2

9 AM (Rooms Available)

Writing Reports

Committee No. 1, State Room A

Committee No. 2, State Room B

Committee No. 3, Taft Room

Committee No. 4, Grant Room

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SPOUSE HOSPITALITY ROOM

7:45 AM

Champaign Room

OHIO DELEGATION TO AMA MEETING

7 AM

Morrow Room

CANDIDATE INTERVIEWS

2 PM

Franklin B, C & D

OMPAC BOARD MEETING

5 PM

Franklin A

OMPAC DINNER/POLITICAL SPEAKER

7 PM

Regency Ballroom South

(Tickets will be sold in advance)

HOUSE OF DELEGATES

7 AM

Registration

Regency Ballroom Foyer

7:45 AM

Spouse Hospitality Room

Champaign Room

9 AM

Final Session

Regency Ballroom

12:30 PM

Installation of 1991-92 President — Dr. Sudimack

ANTICIPATED ADJOURNMENT OF HOUSE OF DELEGATES

2 PM

OSMA COUNCIL MEETING

3 PM

Delaware A

SUNDAY, MAY 19

COUNCILOR DISTRICT CAUCUSES

7 AM

Locations will be posted at registration area

MONDAY, MAY 20

PICO SHAREHOLDERS MEETING

9 AM

Knox Room followed by

PICO BOARD MEETING

10 AM

Champaign Room



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Photos Courtesy of Greater Columbus Convention & Visitors Bureau

Discover Columbus

Those attending this year's annual meeting will have an opportunity to discover Columbus. If it's been a few years since you've visited the Capital City, you're in for a pleasant surprise.

A lack of image hasn't kept Columbus from flourishing. The metropolitan area has 158 commercial projects worth \$2.8 billion either proposed or under construction. A half-dozen new high rises and new hotels now dot the skyline.

Columbus cleverly mixes small-town wholesomeness with a

modern metropolitan setting minus most of the nightmarish aspects of urban life. It's a place where visitors can stop a stranger on the street for directions without fearing for life or limb. But, it is possible to be arrested for jaywalking. So, be forewarned, don't take a chance crossing a downtown street against the light.

Recent articles in the *Wall Street Journal*, *USA Today* and *The Washington Post* refer to Columbus as one of the most prosperous, progressive cities in the nation. It's been labeled a "second tier" metropolis with the first tier

being New York, Chicago and Los Angeles.

Visitors to Ohio's largest city will find an array of affordable attractions, restaurants and special events to keep them busy.

Shopping

A vast \$200 million complex is the latest addition to Columbus shopping. The 112,000-square-foot Columbus City Center houses 135 upscale shops featuring Ann Taylor, Gucci, Abercrombie & Fitch and Victoria's Secret. The glitzy, three-story complex lends itself to browsing through

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out-of-the ordinary shops that specialize in music boxes, teddy bears, jewelry, ties, computer software, clothing, furniture, swimsuits and items from the Metropolitan Museum of New York.

Serving as anchors to these up-and-coming retailers are Marshall Field's, a branch of the old-line Chicago merchandiser, and Jacobson's, a retailer based in Jackson, Mich. A long-time shopping establishment in Columbus, F&R Lazarus & Co., one of the largest, full-service department stores, is easily accessible from the mall without having to venture out into the elements.

The City Center draws droves of shoppers on a daily basis. A record 65,000 visitors per day patronized the mall during its first six months of business.

City Center, located just south of the Statehouse on High Street, is open Monday-Fridays, 10 a.m. to 9 p.m.; Saturdays, 10 a.m. to 7 p.m.; and Sundays from 10 a.m. to 6 p.m.

Dining out

If you love to eat, you've come to the right city. You can dine at one of the skyscraper restaurants or off the beaten path on the side streets of German Village, the Short North or the Brewery District. The menus range from nouvelle cuisine or ethnic, to gourmet or fast food.

Columbus, home to fast food chains like White Castle, Wendy's, Rax, York Steak House, Sister's and Bob Evans Farms, serves the needs of the discriminating palate.

Downtown Restaurants

Christopher's, located on the 31st floor of the Vern Riffe Center for Government and the Arts, features regional American classics in a cosmopolitan atmosphere.

Another panoramic view of the

city is served up at One Nation (located in the Nationwide building). Take the outdoor, glass elevator to the 38th floor where prime rib, Savannah pork roast and mesquite grilled steaks will tantalize your taste buds.

Rigsby's Cuisine Volatile, located in the Short North area, features contemporary American-European, multi-ethnic cuisine cooked in plain view of patrons.

Fifty-Five on the Boulevard, across the street from the Ohio Center, offers a diverse menu of innovative entrees, fresh daily features, and delectable desserts.

A trip to the Brewery District is well-worth the effort. While you're there stop by Pete's Grill & Steak House built in the vaults of the brewery for a variety of steaks, seafood or grilled chicken.

Across from the Statehouse



Columbus City Center houses 135 upscale shops

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you'll find Mario's International. This French-American style restaurant features beef, veal, fowl and seafood most elegantly prepared tableside in the classic French tradition.

German Village

Just minutes from the city's busy downtown is German Village. The narrow, tree-lined brick streets serve as gateways to some fine dining.

Jimmy's Place Upstairs with its cozy, brick and wood decor, white linen tablecloths and fresh flowers entice guests with mesquite-broiled fresh seafood, steaks and veal.

Engine House No. 5, located in a restored 19th century firehouse, claims the title for best seafood in town along with homemade pasta and steaks.

If you want to sink your teeth into an over-stuffed sandwich a la New York deli try Katzinger's Delicatessen, 475 S. Third St. An extensive menu and a vast array of imported foods are available.

For those who prefer a hamburger and fries visit Max & Erma's. Specialities include gourmet hamburgers, onion rings, homemade pasta, ribs, salads and for that sweet tooth, an ice cream sundae bar.

Sight-seeing musts

- Short North, between the OSU campus and Downtown, offers an unexpected Bohemian slice of life. Featuring art galleries, trendy boutiques and restaurants.

- Columbus Museum of Art features permanent European and American collections; traveling exhibitions, decorative arts and a sculpture garden.

- The Statehouse is an example of Greek/Doric architecture, the cupola (dome) is detailed with 24-carat, hand-painted gold leaf. Free tours. Reservations required. Monday-Friday, 9 a.m. to 2 p.m.; Saturday and Sunday, 9 a.m. to 3 p.m.

- COSI, Ohio's Center of Science and Industry, is one of 22 science-technology centers in the world offering hands-on experience in science, technology, health and history.

Bookworms

Hunting down a good book to read? Look no further. The Book Loft in German Village offers 25 rooms chock-full of books. A relatively new bookstore on the city's north side, Borders Bookstore, offers more than 90,000 titles. Sprinkled throughout the city are volumes of other fine bookstores.

Sports fans

If golf's your game, don't be surprised if you recognize a few familiar faces around town May

16-19. Those lucky enough to snag a few tickets can watch the proceedings of the Memorial Tournament at Muirfield from their favorite hole. This major professional golf tournament features top international professional golfers and is hosted by none other than Jack Nicklaus.

Baseball fans can load up on peanuts and hot dogs at a Columbus Clippers game at Cooper Stadium. The AAA Yankee farm team will host the Syracuse Chiefs at 7 p.m. May 16, 17, and 18 and the Rochester Red Wings on May 19 at 2 p.m.

Whether you like to shop, sight-see or eat, it's possible to do it all in Columbus. The Capital City offers a variety of options for its visitors. **OSMA**



Theater-goers can enjoy an evening of entertainment at the renovated Palace Theatre.

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County Medical Societies

Officers, Executive Directors and Meeting Dates

FIRST DISTRICT

Councilor: *K. William Kitzmiller, M.D.*, Town Place Medical, P.O. Box 42467, Cincinnati 45242-0467

ADAMS: Dale L. Mathias, M.D., President and Secretary-Treasurer, 195 Hopping Ave., Peebles 45660-1079. Second Tuesday, February, May, August and November.

BROWN: Tim McKinley, M.D., President, 408 Smith Road, Mount Orab 45154-9416; Ji W. Lee, M.D., Secretary-Treasurer, 900 Mount Orab Park, Georgetown 45121. Third Tuesday.

BUTLER: Louis L. Barich, M.D., President, 549 Main St., Hamilton 45013-3221; Stanley B. Ignatow, M.D., Secretary-Treasurer, 630 Eaton Ave., Hamilton 45013; Mary Kay Johnson, Executive Director, 111 Buckeye St., Hamilton 45012, 513/893-1410. Third Wednesday, alternate months starting November.

CLERMONT: Richard K. Lancaster, M.D., President, 1033 Batavia Pike, Batavia 45103-2303; William B. Selnick, D.O., Secretary-Treasurer, Second & E. Loveland Ave., Loveland 45140. Third Wednesday except July and August.

CLINTON: Bruce E. Staley, M.D., President, 891 West Locust St., Wilmington 45177; Marvin H. Williams, M.D., Secretary-Treasurer, 835 E. Cherry St., Blanchester 45107; Marilyn S. Walker, Executive Secretary, 119

Old Route 122, Lebanon 45036, 513/382-9250. Fourth Tuesday except July, September and December.

HAMILTON: Thomas U. Todd, M.D., President, 212 West Sharon Road, Cincinnati 45246; Susan Weinberg, M.D., Secretary, 8500 Old Carriage Trail, Cincinnati 45242; William J. Galligan, Executive Director, 320 Broadway, Cincinnati 45202, 513/421-7010. Second Tuesday except July and August.

HIGHLAND: No active county medical society.

WARREN: Charles D. Horsley, M.D., President, 397 Ridgewood Lane, Lebanon 45036-1940; Eric O. Haaff, M.D., Secretary, 10550 Montgomery Rd., Suite 24, Cincinnati 45242. Second Tuesday.

SECOND DISTRICT

Councilor: *Walter A. Reiling, Jr., M.D.*, 2200 Philadelphia Drive, Suite 548, Dayton 45406-1830

CHAMPAIGN: Sher S. Guleria, M.D., President, 900 E. Court St., Urbana 43078; Ulysses C. Ruiz, M.D., Secretary-Treasurer, 900 Scioto St., Urbana 43078. Second Wednesday, February, April, May, then as needed.

CLARK: Albert Becker, M.D., President, 30 W. McCreight Ave., Suite 100, Springfield 45504; H. Thomas Staton, M.D., Secretary, 435 S. Burnett Rd., Springfield 45505; Roberta Farish, Executive Secretary, Banc Ohio Bldg., Suite

534, 4 West Main St., Springfield 45502, 513/324-8618. Third Monday except June, July August and December.

DARKE: Carlos K. Menendez, M.D., President, 5317 Meeker Rd., Greenville 45331; Douglas A. Riffell, M.D., Secretary, 702 North Main St., Arcanum 45304. Third Tuesday.

GREENE: Deborah Ward, M.D., President, 1141 N. Monroe Dr., Xenia 45385; Charles Russell, M.D., Secretary, 1141 N. Monroe Dr., Xenia 45385; Judith L. Khoii, Executive Director, 1121 N. Monroe Dr., Room 235, P.O. Box 217, Xenia 45385-0217, 513/376-3783. Third Wednesday, March, June, September and December.

MIAMI: Donald P. Luna, M.D., President, 230 W. High St., Piqua 45356; Ronald B. Pohlman, M.D., Secretary, 300 Kienle Dr., Piqua 45356. First Tuesday except July and August.

MONTGOMERY: Burton G. Must, Jr., M.D., President, 111 West First St., #918, Dayton 45402-1106; Ramesh K. Gandhi, M.D., Secretary, 999 Brubaker Dr., Dayton 45429; Richard G. Tapia, Executive Director, 40 S. Perry St., #100, Dayton 45402, 513/223-0990. Fourth Thursday.

PREBLE: John D. Darrow, M.D., President and Secretary-Treasurer, 228 N. Barron Street, Eaton 45320-1704.

SHELBY: Bruce C. Urbanc, D.O., President, 1445 North Main, Sidney 45365; Kenneth F. Bosslet,

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D.O., Secretary/Treasurer, 1445 North Main, Sidney. Meetings when called.

THIRD DISTRICT

Councilor: *William H. Kose, M.D.*, 200 West Pearl Street, Findlay 45840-1394

ALLEN: Carl S. Wehri, M.D., President, 1775 E. Fifth Street, P.O. Box 458, Delphos 45833-0458; Sarah L. Pirtle, M.D., Secretary-Treasurer, 1220 E. Elm St., Suite 202-204, Lima 45904; Sharon Colgan, Administrative Liaison, 730 West Market St., Lima 45801. Third Tuesday, September through May.

AUGLAIZE: John J. Cruz, M.D., President, 1022 W. Auglaize St., Wapakoneta 45895-1360; Nicanor Atillo, M.D., Secretary-Treasurer, 192 E. Fourth St., Minister 45865-1051. First Thursday, Alternating months starting January.

CRAWFORD: Antonio Rondon, M.D., President, 270 Portland Way S., Galion 44833; William Manthey, M.D., Secretary/Treasurer, 860 Harding Way W., Galion 44833. Meetings when called.

HANCOCK: John M. Rower, M.D., President, 1809 S. Main St., Findlay 45840; Harry Bash, M.D., Secretary, 1920 S. Main St., Suite G, Findlay 45840. Third Tuesday, September through June.

HARDIN: Murli R. Deshmukh, M.D., President, 405 North Main St., Kenton 43326; Subbarao Cherukuri, M.D., Secretary/Treasurer, Hardin Memorial Hospital, Kenton 43326. Second Tuesday.

LOGAN: Donald R. Ebersole, M.D., President, 715 Rush, Bellefontaine 43311-2250; David R. Miller, M.D., Secretary/Treasurer, 212 Irving Ave., Suite A,

Bellefontaine 43311-2226. Meetings when called.

MARION: Walter Beasley, M.D., President, 1040 Delaware Ave., Marion 43302-6414; Stephen Sutherland, M.D., Secretary/Treasurer, Marion General Hospital, McKinley Park Dr., Marion 43302-6397. First Tuesday.

MERCER: Thangaraj Amaran, M.D., President, 950 South Main, Celina 45822-2417; Robert W. Albers, M.D., Secretary/Treasurer, 407 S. Oak, Coldwater 45828. Third Thursday except July and December.

SENECA: Griffith W. Thomas, M.D., President, 506 Van Buren St., Fostoria 44830; Govardhana R. Korrapati, M.D., Secretary/Treasurer, 455 West Market St., Tiffin 44883. Third Tuesday, September through June except December.

VAN WERT: Fred I. Culler, M.D., President, P.O. Box 676, Van Wert 45891; Jerry Sell, M.D., Secretary/Treasurer, 506 West Main St., Rockford 45882-9304. First Tuesday.

WYANDOT: Donald P. Smith, M.D., President, 103 N. Pennington St., Sycamore 44882; Phillip P. Smith, M.D., Secretary/Treasurer, Sycamore Medical Association, P.O. Box 68, Sycamore 44882. Vickie Underwood, Executive Secretary, Wyandot Memorial Hospital, 885 N. Sandusky Ave., Upper Sandusky 43351. Second Tuesday.

FOURTH DISTRICT

Councilor: *Su-Pa Kang, M.D.*, 3900 Sunforest Court, Suite 104, Toledo 43623-4498.

DEFIANCE: Paul E. Brose, M.D., President, 1400 E. Second St., Defiance 43512-2440; Harry A. Doyle, M.D., Secretary/Treasurer,

1400 E. Second St., Defiance 43512. First Saturday.

FULTON: Bernard B. Cohen, M.D., President, 203 Beech St., Wauseon 43567-1402; Estela T. Miquiabas, M.D., Secretary/Treasurer, 725 S. Shoop Ave., Wauseon 43567-1701. Second Tuesday quarterly.

HENRY: Edmundo A. Somoza, M.D., President, Henry County Hospital, Napoleon 43545-9399; Mary Jane Brand, M.D., Secretary-Treasurer, Henry County Hospital, Napoleon 43545-9399. Meetings when called.

LUCAS: John P. Anders, M.D., President, 3900 Sunforest Ct., Toledo 43623; Mary R. Smith, M.D., Secretary, Medical College of Ohio, P.O. Box 10008, Toledo 43699; Lee F. Wealton, Executive Director, 4428 Secor Road, Toledo 43623, 419/473-3200. Council fourth Tuesday, September through June.

OTTAWA: Ih Foo Lin, M.D., President, 1803 N. Concord Circle, Port Clinton 43452; Leonard T. Que, M.D., Secretary/Treasurer, 602 East Sixth St., Suite D, Port Clinton 43452. Second Friday.

PAULDING: Don K. Snyder, M.D., President, Box 57, Payne 45880-0057; Kirkwood A. Pritchard, M.D., Secretary/Treasurer, 119 S. Main St., Paulding 45879-1409. Third Monday.

PUTNAM: David Houston, M.D., President, Box 235, Pandora 45877; David R. Dunkin, D.O., Secretary-Treasurer, East Rice St., P.O. Box 428, Continental 45831. First Tuesday.

SANDUSKY: J. Michael Hazlett, M.D., President and Secretary/Treasurer, 2575 Hayes Avenue, Suite 2, Fremont 43420. Third Thursday.

WILLIAMS: Thomas M. Coon, M.D., President, 507 Newdale Drive, Bryan 43506-1930; Richard L. Hess, M.D., Secretary/Treasurer,

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442 W. High Street, Bryan
43506-1616; Rebecca Cape,
Executive Secretary, Bryan Medical
Group, Inc., 442 W. High St.,
Bryan 43506-1616, 419/636-4517.
Third Tuesday, September,
November, January, March and
May.

WOOD: Woong S. Kim, M.D.,
President, 960 W. Wooster St.,
Suite #104, Bowling Green 43402;
Michael J. Lemon, M.D.,
Secretary/Treasurer, 960 W.
Wooster St., Suite 116, Bowling
Green 43402. Second Thursday.

FIFTH DISTRICT

Councilor: *Ronald L. Price, M.D.*,
Cleveland Clinic, Dept. of
Ophthalmology, A-31, 9500
Euclid Ave., Cleveland
44195-5024

ASHTABULA: In W. Kim,
M.D., President, 2210 S. Ridge
East, Ashtabula 44004-4459; Bruce
H. Robson, M.D.,
Secretary/Treasurer, 70 Crown
Point, Geneva 44041-9134. Barbara
Long, Executive Secretary, 5010
Mapleton Beach, Geneva on the
Lake 44041. Second Tuesday.

CUYAHOGA: O. David
Solomon, M.D., President, 26900
Cedar Road, Beachwood 44122;
Howard L. Levine, M.D.,
Secretary/Treasurer, 9500 Euclid
Avenue, A-71, Cleveland 44195;
George D. Reitz, Executive Vice
President, 11001 Cedar Ave.,
Cleveland 44106, 216/229-2200.
Board of Directors second Tuesday.

GEAUGA: Kevin Chartrand,
M.D., President, 401 South St.,
Bldg. 3B, Chardon 44024; Jeffrey
Cameron, M.D.,
Secretary/Treasurer, 13221 Ravenna
Road, Chardon 44024; Margaret
Pace, Executive Secretary, Geauga
Hospital, 13207 Ravenna Road,
P.O. Box 249, Chardon
44024-0249, 216/286-6131. Second

Thursday, February, June,
September and November.

LAKE: Steven P. Combs, M.D.,
President, 36100 Euclid Ave., #170,
Willoughby 44094; John Ouligian,
M.D., Secretary/Treasurer, 170
Pheasant Run, Mayfield Hts.
44124; Janice A. Vargo, Executive
Secretary, 5900 Dewey Road,
Madison 44057, 216/942-9135.
February, May, September and
November.

SIXTH DISTRICT

Councilor: *Robert C. Reed, M.D.*,
985 Sawburg Avenue, N.E.,
Alliance 44601-3590

COLUMBIANA: Dharam
Batish, M.D., President, 1100
Pennsylvania Ave., East Liverpool,
43920; Patricia Kaine, M.D.,
Secretary/Treasurer, 103 Main St.,
Salineville 43945; Pearl Koenreich,
Executive Secretary, 530 Hawley
Ave., Salem 44460; 216/337-8859.
Third Tuesday, September through
May except December.

MAHONING: Brian S. Gordon,
M.D., President, 515 N. Meridian
Rd., Youngstown, 44509; Kimbroe
J. Carter, M.D., Secretary, St.
Elizabeth Medical Center, P.O. Box
1790, Youngstown 44501; Eleanor
Pershing, Executive Director, 5104
Market Street, Youngstown 44512,
216/788-4700. Third Tuesday,
January, March, May, September,
November and December.

STARK: Louis Kovacs, D.O.,
President, 3140 Lincoln Way E.,
Massillon 44646; Barbara Volk,
M.D., Secretary/Treasurer, 1225
South Main Street, North Canton
44720; Nancy L. Adams, Executive
Director, 4942 Higbee Ave., N.W.,
Suite L., Canton 44718,
216/492-3333. Second Thursday,
October through April.

TRUMBULL: Robert L.
Schaffer, M.D., President, 5000 E.
Market St., Suite 1, Warren 44484;

Robert T. Brodell, M.D.,
Secretary/Treasurer, 2660 E.
Market St., Warren 44483; Marie
Persin, Executive Director, 108
Main Ave., S.W., Suite 902, Warren
44481, 216/394-4556. Third
Wednesday, September through
May except December.

SEVENTH DISTRICT

Councilor: *Walter W. Jones, M.D.*,
East Ohio Regional Hospital,
Physicians Office Bldg., Martins
Ferry 43935

BELMONT: Harlan Sutandi,
M.D., President, Bellaire Clinic,
3000 Guernsey St., Bellaire 43906;
Nermin D. Lavapies, M.D.,
Secretary/Treasurer, 1220 Hughes
Ave., Martins Ferry 43935-1935.
Third Thursday, February through
April and September through
December.

CARROLL: David T. Kukura,
M.D., President, 40 Apache Trail,
Malvern 44644-9529; Nan M.
Bissell, M.D., Secretary/Treasurer,
450 S. Lisbon Street, Box 338,
Carrollton 44615. Third Tuesday.

COSHOCTON: Perry Meadows,
M.D., President, 646 Chestnut
Street, Coshocton 43812; Susan
Magness-Carver, M.D.,
Secretary/Treasurer, 904 Green
Drive, Coshocton 43812-2454.
Second Tuesday.

HARRISON: Isam Tabbah,
M.D., President, 943 E. Market
St., Cadiz 43507; Ajit S. Modi,
M.D., Secretary, 941 E. Market
St., Cadiz 43907. Second Tuesday.

JEFFERSON: William E. Johns,
M.D., President, 203 McLister
Ave., Mingo Junction 43938; John
N. Figel, M.D.,
Secretary/Treasurer, Ross Park
Professional Center, Steubenville
43952. First Tuesday.

MONROE: Donald R. Piatt,
M.D., President/Secretary/
Treasurer, 154 South Main St.,

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Woodsfield 43793. Bimonthly.

TUSCARAWAS: Kanubhai C. Patel, M.D., President, 899 E. Iron Ave., Dover 44622-2030; Daniel J. Clemens, M.D., Secretary/Treasurer, 899 East Iron Ave., Dover 44622-2030; Doris Ferguson, Executive Secretary, Union Hospital, 659 Boulevard, Dover 44622, 216/343-3311. Second Wednesday of odd months.

EIGHTH DISTRICT

Councilor: *Thomas J. Hall, M.D.*, Licking Memorial Hospital, 1320 West Main St., Newark 43055

ATHENS: Robert E. Main, M.D., President, 29 Meadow Lane, Athens 45701-2019; John D. Cunningham, M.D., Secretary/Treasurer, 18 Hooper St., Athens 45701. Second Tuesday, March, June, September and December.

FAIRFIELD: David J. Dunbar, M.D., President, 1500 East Main St., Lancaster 43130; Paul E. Detty, M.D., Secretary/Treasurer, 218 Harmon Ave., Lancaster 43130; Judy Ford, Executive Secretary, 1500 East Main Street, Lancaster 43130, 614/687-5726. Second Tuesday.

GUERNSEY: Robert L. Chess, M.D., President, 904 N. Seventh St., Cambridge 43725-1448; Brady B. Stoner, M.D., Secretary/Treasurer, P.O. Box 477, Cambridge 43725. Meetings when called.

LICKING: Jackie Underwood, M.D., President, 14 Westgate Drive N.E., Newark 43055; Timothy Gatens, M.D., Secretary/Treasurer, Licking Memorial Hospital, 1320 West Main St., Newark 43055; Kathy Bradley, Executive Secretary, Licking Memorial Hospital, 1320 West Main Street, Newark 43055, 614/366-0389. Third Tuesday.

MORGAN: No active county medical society

MUSKINGUM: Charles S. Harrison, M.D., President, 1210 Ashland Ave., Zanesville 43701; Vicki Whitacre, M.D., Secretary/Treasurer, 2435 Dunzweiler Dr., Zanesville 43701-9624. Second Tuesday.

NOBLE: Frederick M. Cox, M.D., President and Secretary/Treasurer, 523 Main St., P.O. Box 330, Caldwell 43724-1324.

PERRY: Walter Wielkiewicz, M.D., President, 409 Lincoln Park Dr., Box 149, New Lexington 43764; William D. Fiorini, M.D., Secretary/Treasurer, 313 North Drive, P.O. Box 430, Somerset 43783-0430. Meet four times yearly.

WASHINGTON: Gregory B. Krivchenia II, M.D., President and Treasurer, 611 2nd St., Marietta 45750-1819. Second Wednesday, September through May except December.

NINTH DISTRICT

Councilor: *Richard Villarreal, M.D.*, 613 Center St., Wheelersburg 45694-1795

GALLIA: Howard E. Linder, M.D., President, Holzer Clinic, P.O. Box 344, Gallipolis 45631; James R. Magnussen, M.D., Secretary-Treasurer, Holzer Clinic, P.O. Box 344, Gallipolis 45631. Four to six meetings per year, when called.

HOCKING: Alfonso Y. Gay, M.D., President, 751 State Rt. 664 N., Logan 43138-9106. John E. Rouch, DO, Secretary-Treasurer, Box 510. Logan, Ohio 43138. Three times yearly.

JACKSON: Patrick B. Ball, D.O., President, 190 Water St., Jackson 45640; Carl J. Greever, M.D., Secretary/Treasurer, 35 Vaughn St., Jackson 45640-1931.

Meetings when called.

LAWRENCE: Sisir K. Bhattacharyya, M.D., President, 2228 South Ninth St., Ironton 45638-2526; A. Burton Payne, M.D., Secretary/Treasurer, 411 Center St., Ironton 45638-1506. Fourth Thursday, September through May.

MEIGS: James E. Witherell, M.D., President, P.O. Box 709, Pomeroy 45794-0709; Wilma A. Mansfield, M.D., Secretary/Treasurer, P.O. Box 709, Pomeroy 45769-0709. Meetings when called.

PIKE: Nola B. de la Pena, M.D., President, 330 East North St., Waverly 45690-1117; Estelito A. Moraleja, M.D., Secretary/Treasurer, 3330 East North St., Waverly 45690. Second Monday.

SCIOTO: John A. Walker, M.D., President, Mercy Medical Plaza, Bldg. A, 1835 Oakland Ave., Portsmouth 45662; Terry W. Bell, M.D., Secretary/Treasurer, 1805 27th St., Portsmouth 45662. Ann Borden, Executive Secretary, 1248 Kinneys Lane, Portsmouth 45662, 614/354-5315. Second Tuesday except February and December when date will be determined.

VINTON: No active county medical society.

TENTH DISTRICT

Councilor: *Claire V. Wolfe, M.D.*, 5521 Indian Hill Road, Dublin 43017

DELAWARE: W. Daniel Tractow, M.D., 5050 Clark Shaw Road, Powell 43065; Lloyd E. Moore, M.D., Secretary/Treasurer, 141 S. Main St., Prospect 43342. First Wednesday, January, April, July and November.

FAYETTE: Beverly Yamour, M.D., President, 215 North Fayette St., Washington C.H., 43160;

Annual Meeting 1991

Robert A. Heiny, M.D.,
Secretary/Treasurer, 616 Willard
St., P.O. Box 457, Washington
C.H. 43160. Second Friday.

FRANKLIN: Ronald E.
Kendrick, M.D., President, 3555
Olentangy River Rd., Suite 1010,
Columbus 43214; Victoria N. Ruff,
M.D., Secretary/Treasurer, 3535
Olentangy River Rd., Columbus
43214. William J. Carbone,
Executive Director, 525 Metro
Place North, Suite 440, Dublin
43017, 614/766-6221. Council —
Second Tuesday, January, March,
May, September and November.

KNOX: Raymond E. Hatton,
M.D., President, Plaza
Professional Center #200, 5 North
Gay St., Mt. Vernon 43050-3241;
William A. Elder, M.D.,
Secretary/Treasurer, 26 Carol
Drive, Fredericktown 43019-1007.
First Wednesday of each month.

MADISON: Martin Markus,
M.D., President, 115 E. High St.,
London 43140; L.B. Wong, M.D.,
Secretary, 210 North Main St.,
London, 43130. Second
Wednesday, Quarterly.

MORROW: Brian L. Bachelder,
M.D., President, 661 West Marion
Road, Mt. Gilead 43338-1027;
William K. Lee,
Secretary/Treasurer, 117 East Main
St., Cardington 43315. First
Tuesday of each month.

PICKAWAY: Michael E. Geron,
M.D., President, 111 Island Road,
Circleville 43113; James A. Mosley,
M.D., Secretary/Treasurer, 610
Northridge Rd., Circleville 43113.
Second Tuesday, September
through June.

ROSS: Cheng-chung Yen, M.D.,
President, 183 E. Water St.,
Chillicothe 45601; Emmanuel A.
Magbag, M.D.,
Secretary/Treasurer, 8 Medical Dr.,
Chillicothe 45601. First Thursday
except June, July and August.

UNION: Brian E. Higgins, D.O.,
President, 286 S. Franklin St.,
Richwood 43344; Michael J.

Conrad, M.D., Secretary/Treasurer,
498 London Ave., Suite H,
Marysville 43040. Quarterly
meetings.

ELEVENTH DISTRICT

Councilor: *Charles G. Adams*,
M.D., 5896 Liberty Ave.,
Vermilion 44089-1053

ASHLAND: W. Stanford
Brechtbuhler, M.D., President, 934
Center St., Ashland 44805-4001;
John Jentes, M.D.,
Secretary/Treasurer, 350 Hillcrest
Dr., Ashland 44805-4052. First
Tuesday.

ERIE: Don J. Young, M.D.,
President, 308 Cedar Brook Lane,
Sandusky, 44870-5433; Thomas J.
Nesgoda, M.D.,
Secretary/Treasurer, 2203
Eaglesnest Circle, Sandusky
44870-6070; Barbara Wolfert,
Executive Secretary, 2710 Scheid
Road, Huron 44839, 419/433-3097.
Second Tuesday, September
through June.

HOLMES: Maurice E. Mullet,
M.D., President, West Main St.,
Berlin 44610; Daniel J. Miller,
M.D., Secretary-Treasurer, P.O. Box
143, Walnut Creek 44687-0143.
Second Tuesday.

HURON: Stephen L. Bollig,
M.D., President; 218 Myrtle Ave.,
Willard 44890-1408; Kerry Allen,
M.D., Secretary/Treasurer, 48
Executive Dr., Norwalk 44857.
Third Wednesday except August.

LORAIN: W. Jeanne McKibben,
M.D., President, 224 West Lorain
St., Oberlin 44074-1026; P. Lal
Arora, M.D., Secretary/Treasurer,
3600 Kolbe Rd., #108, Lorain
44053; Shirley Dalton, Executive
Director, 1875 North Ridge Road
E., Suite E, Lorain 44055,
216/277-9009. Second Tuesday.

MEDINA: Joseph Noreika,
M.D., President, 3637 Medina Rd.,
Medina 44256; Helen Torok, M.D.,

Secretary/Treasurer, 780 E. Smith
Rd., Medina 44256; Shelley
Dunkle, Executive
Secretary, MEDCO, 696 E.
Washington St., Suite 2-B, Medina
44256, 216/725-5331. Quarterly.

RICHLAND: Charles G. Young,
M.D., 370 Cline Ave., Mansfield
44907; Michael Gunzenhaeuser,
M.D., Secretary, 500 S. Trimble
Rd., Mansfield 44903; Becky
Kathrein, Executive Secretary, 295
Glessner Ave., Mansfield 44903,
419/526-8799. Third Thursday
except July and August.

WAYNE: Frank Cebul, III,
M.D., President, 2206 Dorchester
Rd., Wooster 44691; Daniel E.
Stump, M.D., Secretary/Treasurer,
1761 Beall Ave., Wooster
44691-2342. Meetings when called.

TWELFTH DISTRICT

Councilor: *Jack L. Summers*,
M.D., 75 Arch St., Suite B-2,
Akron 44304-1498

PORTAGE: Jen-Nan Yuh, M.D.,
President, 3973 Loomis Parkway,
Suite B., Ravenna 44266-1858;
Atila N. Can, M.D., Secretary-
Treasurer, 202 E. Summit St., Kent
44240-3650. Second Tuesday.

SUMMIT: Charles E. Casto,
M.D., President, 676 S. Broadway
St., Akron 44311; Robert E.
Norman, M.D., Secretary, 777
West Market St., Akron 44303,
Shirley Bee, Managing Director,
430 Grant St., Akron 44311,
216/434-1921. First Tuesday,
January, March, May, September
and November.

*If there are any changes in the
above listings, please contact Kay
Burkett, OSMA's Department of
Field Service, 614/486-2401.*

Annual Meeting 1991

Members of the 1991 OSMA House of Delegates

(Reported at time of publication)

FIRST DISTRICT

ADAMS COUNTY

Delegate:

Dale L. Mathias

Alternate:

Not Reported

BROWN COUNTY

Delegate:

Charles W. Hannah

Alternate:

Not Reported

BUTLER COUNTY

Delegate:

Louis L. Barich
Albert S. Palatchi
Jeffrey Zollett

Alternate:

James P. Baden
Kathleen H. Lang
William M. Stitt

CLERMONT COUNTY:

Delegate:

William B. Selnick

Alternate:

Bienvenido S. Lee

CLINTON COUNTY

Delegate:

John T. Hollon

Alternate:

Bruce E. Staley

HAMILTON COUNTY

Delegate:

Sabino T. Baluyot
Edmund C. Casey
Z. Charles Fixler
Harry H. Fox
Kenneth A. Frederick
William H. Gates
Clyde E. Henderson
Stephen P. Hogg
Edmund Jones
Herbert D. Long, Jr.
Stanley Lucas
Herbert G. Magenheim
Kris Mahalingam
James M. Marrs
Walter E. Matern
Mahendra K. Matta
Robert J. McDewitt
Harold Pescovitz
Pramod R. Rege
Daniel E. Santos
John C. Steiner
Lee J. Vesper
John W. Vester
Stanley J. Wacksman

Alternate:

Prosad J. Athota
F. Jay Ach
Louis Cannon
Frank W. Cianciolo
Robert L. Coith, Jr.
Josef E. Fischer
David Floering
Peter R. Fried

Thomas Helmsworth
John W. Jameson, III
Molly Ann Katz
W. John Kitzmiller
Robert W. Lipp, Jr.
Mahendra Matta
John J. McDonough
Kenneth J. Newmark
James J. Nordlund
James P. Plettner
Thomas U. Todd

HIGHLAND COUNTY

Delegate:

No Active Society

Alternate:

No Active Society

WARREN COUNTY

Delegate:

Thomas E. Fox

Alternate:

Not Reported

SECOND DISTRICT

CHAMPAIGN COUNTY

Delegate:

J. Steven Polsley

Alternate:

Not Reported

Annual Meeting 1991

CLARK COUNTY

Delegate:
James Gibfried
Walter Lawrence
Alternate:
Gary Lau
Abdur Rauf

DARKE COUNTY

Delegate:
William S. Elliott
Alternate:
Daniel Berger

GREENE COUNTY

Delegate:
Shamin A. Shamsi
Alternate:
Barry Luzzi

MIAMI COUNTY

Delegate:
Jerry L. Hammon
Alternate:
Valeriy Moysaenko

MONTGOMERY COUNTY

Delegates:
Herman I. Abromowitz
Gerald Broock
Sean Convery
Arthur Gardikes
Richard Hoback
Stephen T. House
Richard Jenkins
Arlene L. Kagner
Konrad F. Kircher
Alan H. Klein
William J. Marshall
Warren Muth
W. Scott Nekrosius
Alternates:
John Dutro
Charles Moody
J. Gregory Dudash
Ramesh K. Gandhi
Richard Reiling
Steven Swedlund
Michael Besson
David G. Small
Chester K. Robinson
Stephen Lucht
Jae C. Chang

PREBLE COUNTY

Delegate:
John D. Darrow
Alternate:
Not Reported

SHELBY COUNTY

Delegate:
Robert McDevitt
Alternate:
Bruce C. Urbanc

THIRD DISTRICT

ALLEN COUNTY

Delegates:
Leopold Like
Richard L. Faler
Alternates:
Susan L. Hubbell
Ramanath Pai

AUGLAIZE COUNTY

Delegate:
Thomas C. Dozier
Alternate:
Not Reported

CRAWFORD COUNTY

Delegate:
Mehdi Ressallat
Alternate:
Ralph Lyon

HANCOCK COUNTY

Delegate:
Thomas L. Mount
Alternate:
Philip A. Rasor

HARDIN COUNTY

Delegate:
James S. Campbell
Alternate:
Leonard K. Smith

LOGAN COUNTY

Delegate:
Not Reported
Alternate:
Not Reported

MARION COUNTY

Delegate:
Walter Beasley
Alternate:
Brooks H. Sitterley

MERCER COUNTY

Delegate:
Not Reported
Alternate:
Not Reported

SENECA COUNTY

Delegate:
James A. Murray
Alternate:
Randolph D. Gibbs

VAN WERT COUNTY

Delegate:
Jack H. Cox
Alternate:
Thomas E. Lautzenheiser

WYANDOT COUNTY

Delegate:
Donald P. Smith
Alternate:
Phillip P. Smith

FOURTH DISTRICT

DEFIANCE COUNTY

Delegate:
Benedict B. Lenhart
Alternate:
Richard G. Smith

FULTON COUNTY

Delegate:
Randall J. Bowman
Alternate:
Rebecca L. McClarren

HENRY COUNTY

Delegate:
Edmundo A. Somoza
Alternate:
Romeo S. Flora

Annual Meeting 1991

LUCAS COUNTY

Delegates:

John P. Anders
Alcuin D. Bennett
Leo J.P. Clark
Roland A. Gandy, Jr.
Jerome Kimmelman
Richard H. Koop
Richard D. Ruppert
William C. Sternfeld
Lance A. Talmage
Richard J. Wiseley
Donna A. Woodson

Alternates:

Stephen P. Bazeley
Riaz N. Chaudhary
Steven E. Gordon
Crystal R. Goveia
Robert E. Kose
Donald B. Marshall
Rudy N. Nucklos
John H. Robinson
Herbert E. Stockard
Leslie E. Whitmire
Peter J. Wilson

OTTAWA COUNTY

Delegate:

J. Glenn Trippe

Alternate:

John F. Bodie

PAULDING COUNTY

Delegate:

Kirkwood A. Pritchard

Alternate:

Not Reported

PUTNAM COUNTY

Delegate:

David Houston

Alternate:

Anna M. Horstman

SANDUSKY COUNTY

Delegate:

J. Michael Hazlett

Alternate:

Not Reported

WILLIAMS COUNTY

Delegate:

John E. Moats

Alternate:

Robert W. Dilworth

WOOD COUNTY

Delegate:

Douglas S. Hess

Alternate:

Woong S. Kim

FIFTH DISTRICT

ASHTABULA COUNTY

Delegate:

No Representatives Were Elected

CUYAHOGA COUNTY

Delegates:

Karl S. Alfred
Donavin A. Baumgartner
Victor M. Bello
Wilma F. Bergfeld
Leon A. Brown
John H. Budd
Theodore J. Castele
Carl A. Culley, Jr.
Nicholas G. DePiero
Stanley L. Fox
Michael H. Frankel
Richard B. Fratianne
John J. Gaughan
Gita P. Gidwani
Thomas E. Gretter
Donald W. Junglas
Edward G. Kilroy
Henry G. Krueger
George P. Leicht
Howard L. Levine
Lawrence J. McCormack
Beno Michel
Richard J. Nowak
James L. Phillips
Anne L. Rassiga
Leonard P. Rome
O. David Solomon
Peggy Jeanne St. Clair
Frederick T. Suppes
Warner W. Tuckerman
Daniel W. van Heeckeren
Robert M. Zollinger, Jr.

Alternates:

Mahmoud Adam
Michael T. Barkoukis
Bert Brown

Joseph B. Carter
John Dorsky
Charles Emerman
Mourad H. Fanous
Roger Ferreri
Carl W. Groppe
Jon A. Hardacre
Philibert Jones, III
Terrence Kilroy
Boris Komrovsky
Unni P.K. Kumar
Allan B. Kunkel
Thomas J. Lavin
Alan Lichtin
John H. Nickels
Michael L. Nieder
Alan M. Oliver
Jacob F. Palomaki
John G. Poulos
William J. Reinhart
Ellen Rothchild
William H. Seitz, Jr.
Nandlal Varyani
Clifford J. Vogt
Raymond J. Votyka
William O. Wagner
Edward C. White

GEAUGA COUNTY

Delegate:

Kevin Chartrand

Alternate:

Bruce Andreas

LAKE COUNTY

Delegates:

Janet M. Blanchard
Mahmood Pazirandeh
Jeffrey Siminovitch

Alternates:

Daniel Cudnik
Janis A.R. Hedin
Robert Stegmayer

SIXTH DISTRICT

COLUMBIANA COUNTY

Delegate:

John R. Madison

Alternate:

Dharan Batish

Annual Meeting 1991

MAHONING COUNTY

Delegates:

J. James Anderson
Brian S. Gordon
James A. Lambert
Lloyd E. Slusher
Hai-Shiuh Wang
Karl F. Wieneke, Jr.

Alternates:

Ernesto Angtuaco
Jane F. Butterworth
Denise L. Bobovnyik
David J. Dunch
Murali Guthikonda
Daniel W. Handel

STARK COUNTY

Delegates:

Robert DiSimone
Louis Kovacs
Andres B. Lao
Raymond J. McMahon
Robert C. Reed
Charles E. Smith
David Utlak

Alternates:

George Ewing
Edward E. Grable
W. Henry Kofol
Vinayak Mehta
Hannelore Smith
George Vogelgesang
Donald Zimmerman

TRUMBULL COUNTY

Delegates:

Irvine G. Milheim, Jr.
Robert W. Taylor
John O. Vlad

Alternates:

Alfredo Gorospe
James M. Sudimack
Michael C. Thomas

SEVENTH DISTRICT

BELMONT COUNTY

Delegate:

Harlan Sutandi

Alternate:

R. Dean Coddington

CARROLL COUNTY

Delegate:

Nan M. Bissell

Alternate:

Not Reported

COSHOCTON COUNTY

Delegate:

Linda J. Magness

Alternate:

Robert Gwinn

HARRISON COUNTY

Delegate:

Elias Freeman

Alternate:

John Kuziak

JEFFERSON COUNTY

Delegate:

James Cottrell

Alternate:

Ronald C. Agresta

MONROE COUNTY

Delegate:

Donald R. Piatt

Alternate:

Not Reported

TUSCARAWAS COUNTY

Delegate:

Daniel J. Clemens

Alternate:

Not Reported

EIGHTH DISTRICT

ATHENS COUNTY

Delegate:

William H. Allen, Jr.

Alternate:

Not Reported

FAIRFIELD COUNTY

Delegate:

John E. Lloyd

Alternate:

Bradley Lewis

GUERNSEY COUNTY

Delegate:

Thomas D. Swan

Alternate:

H.D. Miller

LICKING COUNTY

Delegate:

Owen Lee

Alternate:

Jackie L. Underwood

MORGAN COUNTY

Contact Person:

Barbara Murrell

MUSKINGUM COUNTY

Delegates:

John W. Ray
Michael M. Zimmerer

Alternate:

Not Reported

NOBLE COUNTY

Delegate:

Frederick M. Cox

Alternate:

Not Reported

PERRY COUNTY

Delegate:

Walter Wielkiewicz

Alternate:

Not Reported

WASHINGTON COUNTY

Delegate:

Gregory B. Krivchenia

Alternate:

Not Reported

NINTH DISTRICT

GALLIA COUNTY

Delegate:

Carol M. Sholtis

Alternate:

Rebecca T. Strafford

HOCKING COUNTY

Delegate:

Roy R. Bontrager

Alternate:

Rowan D. Labrador

Annual Meeting 1991

JACKSON COUNTY

Delegate:

John W. Zimmerly

Alternate:

Carl J. Greever

LAWRENCE COUNTY

Delegate:

Mary Legenza

Alternate:

A. Burton Payne

MEIGS COUNTY

Delegate:

James E. Witherell

Alternate:

Not Reported

PIKE COUNTY

Delegate:

Esteliot A. Moraleja

Alternate:

Not Reported

SCIOTO COUNTY

Delegate:

Jack Borders

Alternate:

Bernard R. Gibson

VINTON COUNTY

Delegate:

No Active Society

Alternate:

No Active Society

TENTH DISTRICT

DELAWARE COUNTY

Delegate:

Michael D. Reuter

Alternate:

David S. Smith, Jr.

FAYETTE COUNTY

Delegate:

Robert A. Heiny

Alternate:

Abdiel Lorente

FRANKLIN COUNTY

Delegates:

James E. Barnes

Ronald B. Berggren

Janet K. Bixel

Louis J.R. Goorey

William Hamelberg

William H. Havener

Marilyn J. Huheey

Ernest W. Johnson

Owen E. Johnson

Ronald E. Kendrick

Paul S. Metzger

William A. Millhon

William T. Paul

Gerald M. Penn

James J. Powers

Victoria Ruff

Manuel Tzagournis

Mary Jo Welker

Alternates:

Edward T. Bope

John A. Burkhart

A. Robert Davies

Joanna M. Demas

Nino Di Iullo

John A. Drstvensek

Antoinette P. Eaton

Marvin G. Green

Charles J. Hickey

Victor H. Hinrichs

Lester E. Imboden

Teresa C. Long

James A. Mechenbier

Michael H. Mishkind

Ali Mokhtari

Richard G. Orlando

H. William Porterfield

Delphis C. Richardson

William L. Smead

Joan E. Wurmbrand

KNOX COUNTY

Delegate:

Edward E. Yu

Alternate:

William A. Elder

MADISON COUNTY

Delegate:

C. Terrill Hay

Alternate:

Brawley Arikawa

MORROW COUNTY

Delegate:

Brian L. Bachelder

Alternate:

Not Reported

PICKAWAY COUNTY

Delegate:

Vernon G. Bolender

Alternate:

Jeffrey W. Milks

ROSS COUNTY

Delegate:

Joseph S. McKell

Alternate:

David A. Pack

UNION COUNTY

Delegate:

John R. Evans

Alternate:

Brian E. Higgins

ELEVENTH DISTRICT

ASHLAND COUNTY

Delegate:

William M. Emery

Alternate:

Michael D. Stencel

ERIE COUNTY

Delegate:

Charles J. Everett

Alternate:

Lawrence McCormack

HOLMES COUNTY

Delegate:

Maurice E. Mullet

Alternate:

M. Robert Huston

HURON COUNTY

Delegate:

Nino M. Camardese

Alternate:

Pura Garin-Vargas

LORAIN COUNTY

Delegates:

William L. Hassler

Annual Meeting 1991

W. Jeanne McKibben
Roy H. Thomas
Daniel C. Zaworski

Alternates:

James J. Andrasko
Fred Hofman
Nicandro V. Leano
Thomas R. Martin

MEDINA COUNTY

Delegate:

Otto J. Kunst

Alternate:

Bennis E. Grable

RICHLAND COUNTY

Delegates:

Joel E. Kaye
Joseph E. Stolfi

Alternates:

Richard L. Clark
William E. Schamadan

WAYNE COUNTY

Delegate:

John W. Thomas

Alternate:

David B. Reynolds

TWELFTH DISTRICT

PORTAGE COUNTY

Delegate:

Donald A. Hammel

Alternate:

Michael Mastromatteo

SUMMIT COUNTY

Delegates:

William Dorner, Jr.
C. William Keck
W. Paul Kilway, Jr.
Joseph L. Kloss
E. Gates Morgan
T.G. Olbrych
Charles A. Peter
F.J. Waickman

Alternates:

Charles E. Casto
John A. Fink
Paul D. Gatewood
Melodie Morgan-Minot
David M. Sokol
Ronna Staley
Abdon E. Villalba

Continued on page 211

Candidate for Secretary-Treasurer

John F. Kroner, MD

John F. Kroner, MD, a Youngstown native, graduated cum laude from Ohio University in 1958 and received his medical degree from Stritch School of Medicine, Loyola University, in Chicago in 1962. He then returned to Youngstown, taking both his internship and residency at St. Elizabeth Hospital before enlisting for two years of service as a captain in the United States Air Force.

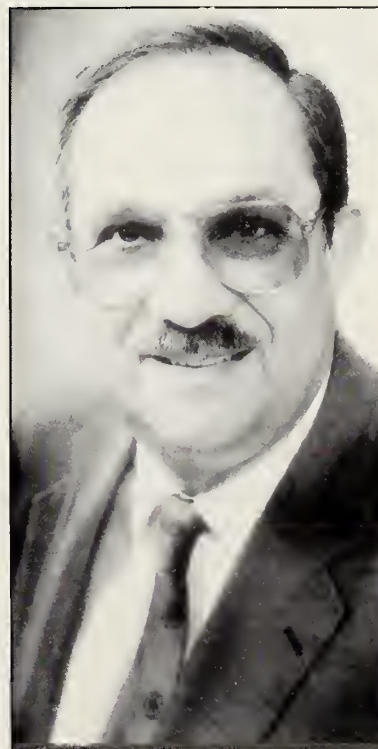
Dr. Kroner is now a board-certified obstetrician-gynecologist in private practice in Athens. He recently retired from his position as chief of obstetrics at O'Bleness Memorial Hospital, a post he filled for 17 years. Dr. Kroner has remained active in organized medicine at both the county and state levels. His most recent duties have been as Secretary-Treasurer of the Ohio State Medical Association, a position to which he was appointed at last

year's Annual meeting. Dr. Kroner also served the OSMA for five years as its Eighth District Councilor, and as a delegate to the OSMA for 17 years, chairing several of the association's resolutions committees during that time. In addition, he has served as a member of the OSMA Committees on Education, Membership, Legislation, Maternal and Neonatal Health and the House of Delegates Policy Committee. He is also a past president of the Athens County Medical Society, a past chief of staff at O'Bleness and a clinical professor at OUCOM.

In his spare time, Dr. Kroner has spent 16 years as a volunteer team physician at Athens High School. He also enjoys hunting, fishing and golf, and he breeds, trains and races standard-bred horses.

Dr. Kroner and his wife, Donna, have been married for 31 years, and have four children,

John III, a veterinarian; Mark; Kristen; and Gregory. **OSMA**



Third-Party Payor Contracts

BEFORE YOU SIGN

ON DOTTED LINE

Ohio physicians who practice in large urban areas may see as many as 20 to 25 third-party payor contracts pass across their desk each year. While

their non-urban colleagues may see fewer contracts, they report a proliferation of these documents in their practices as well.

Obviously, third-party payor contracts have become a part of practicing medicine today, but they should not be taken lightly. What you

don't know can definitely hurt you.

Deborah Bahnsen, JD, who serves as legal counsel for OSMA's Ombudsperson department, has heard the horror stories that come as the result of a hasty signature. Bahnsen reads and offers an analysis of third-party payor

contracts as a service to OSMA members. Because of anti-trust regulations and OSMA not-for-profit status, this analysis is not offered as legal advice, nor will you be counseled on whether or not to sign the contract. However, Bahnsen will offer you points to keep in mind as you weigh your decision. A complete list of the dos and don'ts of contracting are included here, yet there are some particular areas of caution that Bahnsen suggests physicians consider carefully before signing.

"First of all, review the contract's payment mechanisms. Too many times, a physician will enter into a contract without fully understanding how they will be paid," she says. Don't assume, for example, that the party with which you are signing is the payor. A conglomerate or other entity may, in fact, be the payor, and unless you're aware of that, and of the financial health of that entity, you may risk not getting paid for the services you perform if that entity suddenly goes bankrupt.

Second, understand the circumstances by which you may have your contract terminated.

"Physicians are told that their contract has been terminated, and



Reimbursement

in many cases, they have no idea why. Yet, the way some contracts are written, the payor doesn't have to provide reasons for termination. They just do it," says Bahnsen. Most contracts are renewable annually. If termination of a contract can take place prior to that time, you need to know that — and you need to know *how* termination can take place.

"In most cases, you or the payor can terminate the contract if the other party is notified in writing a designated number of days ahead," Bahnsen explains.

A third area in which Bahnsen advises caution is the number of subscribers you allow into your practice. She recalls one incident where a physician lost at least one third of the patients in his practice when his contract was suddenly terminated.

"We recommend that you negotiate the ability to limit the number of patient-subscribers," Bahnsen says.

Bahnsen recommends running any contract you are considering signing past an attorney, although she says it's possible for a physician or office manager to become proficient at studying these documents if they devote enough time to them. Four to five hours would probably be a proper amount. In any case, she urges physicians to read the contracts carefully before signing them.

"Physicians are often under pressure to sign quickly. The payor may give a short time-line for signing the contract, and often the payor's representative is there telling you everything is OK."

If you don't understand the payment mechanisms, contract terminations or your obligations with regard to claims submission, prior authorization, utilization review or any of the other points in the contract, however — ask. Know what you're signing.

"If it says you are obligated to perform procedures according to a physician's manual, make sure you get a copy of that manual and study it to see if those procedures differ from your normal ones," Bahnsen says.

If they do, consider whether or not you are willing to change your office procedures for these subscriber patients. That's especially important if you are engaged in more than one contractual arrangement.

"It can be confusing to office staff when they must perform procedures one way for one set of patients, and another way for another set of patients," Bahnsen says, so factor that into your decision.

Another factor that needs to be considered is the payor's reputation. Is this a solvent company, well-established in the community or a fly-by-night outfit?

"They check your background, so check theirs," Bahnsen suggests.

The local Chamber of Commerce, the State Department of Insurance and all those who store public records can facilitate your search.

Ask who the principals are, who owns the shares, what their track record is and what kind of experience they have.

"If they are reluctant to provide you with information, that should tell you something," says Bahnsen.

Of course, the time for any negotiations is before you sign on the dotted line. Changing things mid-term is virtually impossible. Still, negotiations can be opened again at the time of your contract's renewal, and if you or your office staff have experienced problems over the year, working under the contract's terms, you *should* try to negotiate those portions that you found difficult.

Renewals probably don't have to be as carefully scrutinized as the original contract, Bahnsen says, but they should at least be carefully read to make sure that provisions haven't been added or deleted.

If you have a contract that you would like Bahnsen to review, you may address it to: Deborah Bahnsen, JD, Ombudsperson Department, Ohio State Medical Association, 1500 Lake Shore Drive, Columbus, OH 43204-3824. She would like to see the contracts before you sign them, and well ahead of the payor's deadline, if possible. Remember, her analysis is just that. It is not legal representation or a recommendation.

Following are other "Dos and Don'ts of Contracting," prepared by Bahnsen. **OSMA**

Before You Sign . . . Seven Key Points You Should Want Answered

- How will you be paid?
- How may your contract be terminated?
- How many subscribers will you allow into your practice?
- Do you understand all of your obligations under this contract?
- If the contract outlines office procedures that are different from yours, are you willing to make those changes?
- Have you examined the background of the company with which you are contracting?
- Have you, or preferably an attorney, carefully read over this contract?

Reimbursement

OSMA Provides Contract Review for Physicians

Analysis of the following contracts are available:

Name of Corporation	Date Received
Akron City Health Systems	February 19, 1991
All Care, Inc.	July 7, 1989
Blue Guardian Insurance Co.*	April 22, 1990
CIGNA Healthplan Inc.	November 5, 1990
CMIC Health Maintenance Plan	April 21, 1987
CMIC Preferred Medical Plan	February 27, 1990
Community Health Services, Inc.**	May 22, 1989
Creative Health Services Plan, Inc.	July 18, 1989
Day-Med HMP, Inc.	May 2, 1990
Dayton Area Health Plan	November 13, 1987
Equicor	April 30, 1990
First Ohio Preferred, Inc.	June 1, 1988
Health Power of Dayton, Inc.	February 25, 1991
Life Care Plus	February 12, 1991
Lincoln Nat'l Admn. Services, Inc.	May 17, 1989
Lincoln Nat'l Health Plan	April 27, 1990
MGH Preferred Care, Inc.	September 27, 1988
Northwest Physicians, Inc.	April 18, 1988
Ohio Health Choice Plan	August 3, 1987
Paramount Healthcare Plan	February 19, 1987
Partners Healthplan of Northern Ohio	February 22, 1991
Partners National Advantage	July 27, 1987
Path Health Network of Ohio	December 20, 1991
Peak Health Plan of Ohio	May 19, 1989
Physicians Health Plan	October 20, 1990
Private Healthcare Systems Limited	October 2, 1989
Prudential Primary Care Physician Agr	February 19, 1991
Super Blue (BCBSO)	February 19, 1991
Travelers Insurance Co.	July 22, 1987
Travelers Insurance Co.	April 14, 1988
Travelers Managed Care System Agr	February 25, 1991
U.S. Behavior Care	February 12, 1991
U.S. Health Plan, Inc.	November 5, 1990
Western Ohio Healthcare Plan	June 26, 1990
Wright Health Plan	November 5, 1990

For more information or for copies of an analysis, please contact the OSMA Ombudsperson staff at 1-800-766-OSMA.

*Blue Guardian Insurance Company does business as MedChoice.

**Community Health Systems, Inc. does business as Health Systems Preferred.

Dos and Don'ts of Contracting

DO:

Blank terms, vagueness

- Make sure all contract terms are filled in prior to signing.
- Clarify any vague or open-ended terms. Ask for supporting documentation (i.e. financial statements, bylaws, etc.) for any unclear statements.
- Make sure contracts contain all provisions or guarantees that were made to you orally.
- If the business entity is unwilling to alter a "standard" contract, ask for an opinion letter from the business entity's legal counsel answering any questions that you might have regarding the contract. Keep this on file with the contract.
- Obtain and *read* a copy of any documents referred to in the contract. They are as legally binding as the contract itself.
- Ask for a copy of any contract with members, so the extent of your obligation to provide services is known.

Referrals

- Ask for a list of participating physicians so you know how your referral patterns will be affected by signing the contract.
- Ask for clarification of this situation: Your back-up physician covers you during emergencies, illness or vacation but is not a participating physician of the business entity.
- Check to see if specialty services can be performed only upon referral of a primary care physician (gate-keeper) or whether a patient can self-refer.

Compensation and Withholding

- Determine the mechanism for payment of fees (i.e. formula,

UCR, discounting, etc.)

Remember, you have no right to know actual fees of another physician or payment to any other physician.

- Find out how frequently payment levels are adjusted (i.e. annually, biannually).
- Determine the % withhold, if any, and how this figure can be modified. Determine when and how much of the withhold can be paid back to physicians.
- Verify who makes the decision as to payback and reserves.
- If withhold percentages can be adjusted upward on an emergency basis, determine who must approve this action and for what period of time the adjusted rate remains in effect.

Liability

- Review the business entity's liability insurance to determine the extent of coverage.
- Discuss the contract with your malpractice insurance carrier to make sure you are covered for all activities you are required to perform under the contract.
- Ascertain if there is a minimum level of liability insurance you must carry to participate in the business entity.
- Review liability provisions carefully to determine that there is no shifting occurring.
- Find out whether the business entity also maintains liability insurance, its limits and scope of coverage.
- Find out if the business entity's liability insurance is primary or excess coverage.

Billing and Payment

- Review the business entity's billing procedures to determine if there is a standardized billing

form. If so, check to make sure the form is compatible with your computerized billing program of your current billing protocols.

- Determine what information must be submitted with a bill to make it complete for purposes of receiving reimbursement.
- Ask how long it takes the business entity to notify a physician that a claim is incomplete and must be resubmitted.
- Find out the appeals mechanism for payment disputes.

Appeals

- Make sure all utilization review procedures (e.g., prior authorization, pre-admission review, etc.) are clearly explained and a mechanism for appeal is clearly identified.
- Determine *who* has the right to appeal adverse UR decisions: the physician, the patient or both.
- Ascertain who makes the final determination in a decision to deny services or payment.
- Determine if arbitration is being suggested as a mechanism for appealing contract or payment disputes. If so, ascertain whether the decision of the arbitrator is binding, as well as who is responsible for costs.

Termination

- Find out what type of notice you must give to terminate the contract.
- Find out if you can terminate the contract with no notice if there is just cause.
- Determine what type of ongoing patient obligation you assume even after termination of the contract.

Reimbursement

- If you are in an "exotic" specialty, have your attorney review the contract to determine if you will have difficulty terminating it.

Miscellaneous

- Know who controls the business entity with which you are contracting.
- Check to see who are the business entity's officers and directors. Are they reputable?
- If possible, check for past activity of the business entity and its controlling officers — were there any prior failed businesses?



- Check for any outstanding lawsuits against the business entity.
- Review the office procedures/billing procedures

manually with your office staff prior to signing.

DON'T:

- Rely on oral statements as to what the contract means.
- Assume you can change unfavorable terms once the contract is signed.
- Assume liability that will not be covered by your malpractice insurance or the business entity's insurance.
- Decide jointly, with other physicians, to join or quit a certain business group unless the physicians are incorporated. **OSMA**

Bimonthly
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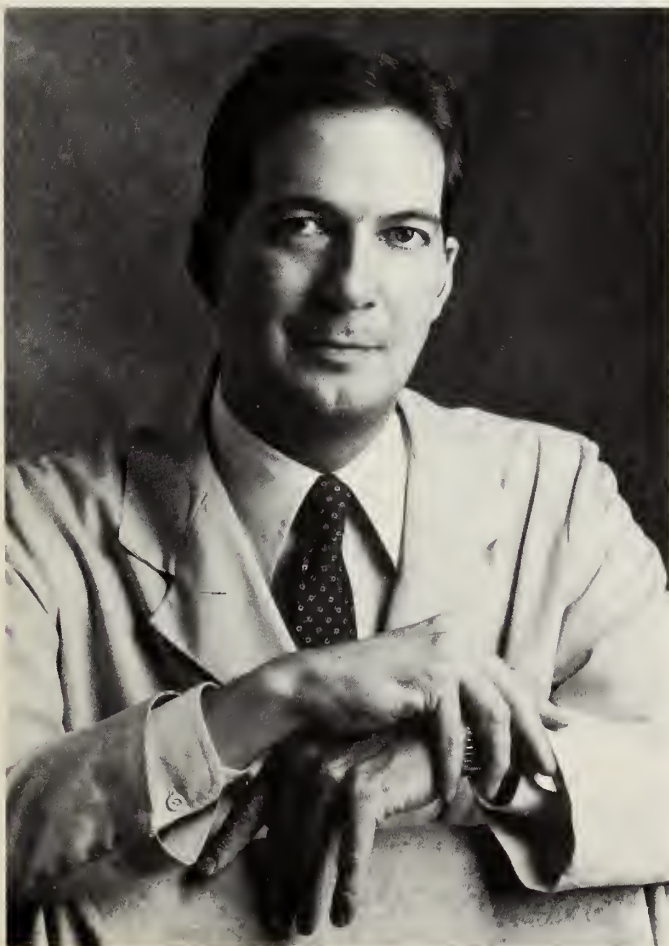
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Obituaries

HUGH R. ANDERSON, MD,
North Olmsted; Case Western Reserve University School of Medicine, 1943; age 72; died January 5, 1991; member OSMA and AMA.

JOSEPH C. CROSS, MD,
Columbus; Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1944; age 72; died January 13, 1991; member OSMA and AMA.

WARREN W. DAUDISTEL, MD,
Hamilton; University of Cincinnati College of Medicine, 1956; age 60; died January 31, 1991; member OSMA.

FREDERICK DINEEN, MD,
Painesville; McGill University Faculty of Medicine, Montreal, Quebec Canada, 1926; age 88; died January 19, 1991; member OSMA and AMA.

RICHARD R. EVANS, MD,
Cleveland; Albany Medical College of Union University, Albany, NY, 1943; age 74; died December 30, 1990; member OSMA and AMA.

JOSEPH FOGARTY, DO,
Youngstown; University of Health Sciences College of Osteopathic Medicine, Kansas City, KS, 1960; age 60; died June 19, 1990; member OSMA and AMA.

FERENC M. FREIMANN, MD,
Cleveland; Orvosi Fakultás Szegedi Orvostudományi Egyetem Szeged Hungary, 1941; age 73; died December 23, 1990; member OSMA.

WILLIAM HUTCHISON, MD,
Columbus; Ohio State University College of Medicine, 1943; age 72; died January 18, 1991; member OSMA.

JAMES JAGODZINSKI, MD,
Toledo; St. Louis University School of Medicine, St. Louis, MO, 1964; age 51; died January 28, 1991; member OSMA and AMA.

MICHAEL I. KANDEL, MD,
Worthington; Ohio State University College of Medicine, 1975; age 40; died January 17, 1991; member OSMA and AMA.

DOMINIC MANDALFINO, MD,
Columbus; Northeastern Ohio University College of Medicine, 1987; age 29; died February 1, 1991; member OSMA and AMA.

SPENCER NORTHUP, MD,
Sylvania; University of Michigan Medical School, Ann Arbor, MI, 1938; age 78; died January 26, 1991; member OSMA and AMA.

ARNOLD D. PIATT, MD, Boca Raton, FL; Ohio State University College of Medicine, 1933; age 83; died January 1991; member OSMA and AMA.

ABDUR A. RASHID, MD,
Youngstown; Dacca Medical College, Dacca, East Pakistan, 1957; age 56; died December 26, 1990; member OSMA and AMA.

WILLIAM B. SEYMOUR, MD,
Chagrin Falls; Case Western Reserve University School of Medicine, 1935; age 80; died January 27, 1991; member OSMA and AMA.

LOUIS J. TILTON, MD,
Frazeyburg; Northwestern University Medical School, Chicago, IL, 1933; age 86; died January 9, 1991; member OSMA and AMA.

JOSEPH TOMASHEFSKI, MD,
Ft. Myers, FL; Hahnemann

Medical College of Philadelphia, Philadelphia, PA, 1947; age 68; died January 26, 1991; member OSMA.

THOMAS W. WATSON, MD,
Wayne; Case Western Reserve University School of Medicine, 1934; age 82; died January 21, 1991; member OSMA and AMA.

DAVID R. WEIR, MD, Cuyahoga Falls; Harvard Medical School, Boston, MA, 1936; age 79; died January 17, 1991; member OSMA and AMA.

JOHN WORTHMAN, MD,
Kettering; Ohio State University College of Medicine, 1950; age 70; died February 7, 1991; member OSMA and AMA.

AARON B. YASINOW, MD,
Cleveland; Case Western Reserve University School of Medicine, 1924; age 91; died January 20, 1991; member OSMA and AMA.

MICHAEL YUKEVICH, MD,
Pittsburgh, PA; University of Pittsburgh School of Medicine, Pittsburgh, PA, 1937; age 78; died January 25, 1991; member OSMA and AMA.

Leprechaunism

(Donahue's syndrome)

This syndrome was first described by Donahue in 1948 under the term dysendocrinism for a female infant with peculiar elfinlike facies, hirsutism, and multiple endocrine abnormalities.¹ Another child with the same condition born to the same parents, was reported in 1954, and designated as leprechaunism, a rare familial disorder.² Other features include failure to thrive, resulting in a marasmic appearance, alteration of carbohydrate metabolism with

hypoglycemia, and sexual precocity.³ The major endocrinological findings have been hypoplasia of the adrenal and thyroid glands with large ovaries containing small follicular cysts.⁴ The ovarian changes probably start in the seventh intrauterine month, with consequent hyperestrogenism, leading to enlarged nipples and external genitalia,

hypertrichosis, increased excretion of 17-ketosteroids, hyperplasia of the islets of Langerhans, and large kidneys with tubular calcium deposits. There is also suppression

of growth hormone with consequent delay in bone growth.

The basic defect appears to be a primary insulin resistance owing to a defect in the target cell,⁵ which is transmitted as a rare familial disorder.² The presence of ovarian cysts and increased estrogens suggests that Leprechaunism is the intrauterine and infantile equivalent of the Stein-Leventhal syndrome which occurs in adults.⁴

In Irish folklore, a leprechaun is a hairy, mischievous pigmy sprite who repairs shoes and carries a purse containing a shilling.⁶ Although the facies are described as elfinlike, the syndrome is different than the Elfin Syndrome, which is associated with hypercalcemia and supravalvular aortic stenosis. It has been pointed out that many marasmic infants from various causes result in an elfin appearance.⁷ There appears to be some confusion between leprechauns and elves in this eponym, the former being found in Irish folklore and the latter in Teutonic mythology. Their facial appearance is quite variable in illustrations, but both are of dwarf size.

There has been an admonition that "terminologic vigilance must be exercised that the ponderous Leprechaunoid not be introduced on the scene of the charming Leprechaun."⁸ Another related comment is that leprechauns of

Continued on page 184



A Two-Way Street

IMPROVING PATIENT COMMUNICATIONS

Telephone

If one were to ask a physician what his or her office's most important piece of equipment

is, you'd be hard pressed to elicit the response, "My telephone." But when it comes to communicating with your patients, selecting the proper phone system — and using it correctly — is key.

The first question physicians

should ask when outfitting their practice with telephones is, should I lease or buy? "I would buy if you're going to stay in the same place for a period of time," says Robert Hecht, program director of the AMA's Department of Practice Management. At the same time, he says, "I wouldn't go down to K-Mart and buy a couple of phones.

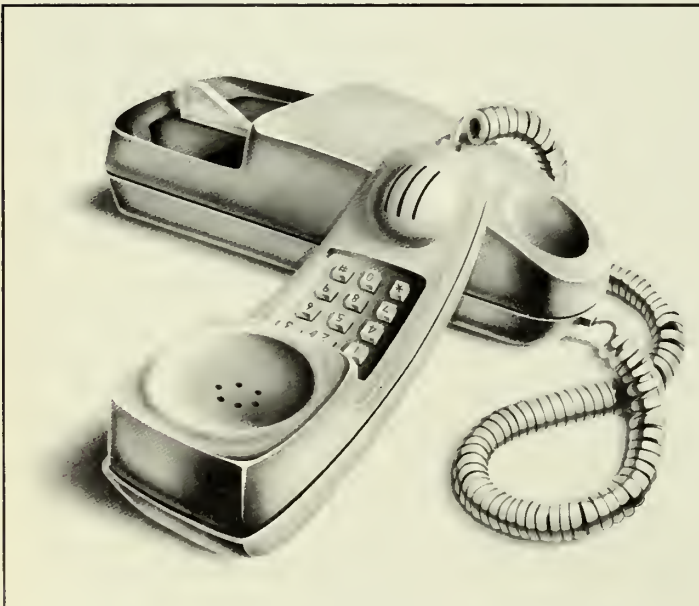
You should have an integrated system and you should stick to brand names."

Hecht, who was in Columbus recently to conduct a seminar entitled "Starting Your Practice," says the number of phone lines a practice should have depends on the number of physicians, for example one physician, two incoming lines, one private line; two physicians, four incoming lines; three physicians, five incoming lines. Also, he says, "Make sure you can add lines easily without having to spend a lot of extra money down the road."

Before you settle on a telephone system, however, Hecht says to make sure you try to transfer a call "because you have to be an engineer to figure out some of the equipment out there. Make sure it's easy to use."

Some options physicians may choose are call forwarding, office intercoms and hands-free capability (such as a headset), "which is a good idea if you have someone who answers the phone all day."

Another option some physicians may wish to consider: installing an extra phone in the reception area for patients' use. "It's a nice touch," says Hecht, adding, "Put a toll restriction on it so long-distance calls can't be made, but don't get a pay phone. It looks tacky and it probably won't even



Marketing

pay for itself because of the low volume (in usage)."

Of course, the way your phones are answered by your staff is just as important, if not more so, as the equipment itself. "Train your staff to use a professional manner," Hecht says. "Get your staff to answer the phone the way you want it answered. If you're out of town, they should say you're unavailable, *not* on vacation. Also, they shouldn't give any information out about a patient — not to insurance companies or anyone — without patient consent.

"All calls that come in regarding medical care should be charted," Hecht continues. "We constantly hear lawyers who tell us that some aspect of a case is related to a phone call, so make sure you chart those conversations."

Because physicians' schedules don't often allow them to immediately take patient calls, one solution is to schedule a daily "phone time," when patients can call and reach the physician with their questions and concerns. Another option — and one Hecht prefers — is to schedule two times a day when patients' calls can be returned. That way, he says, not only will the physician have the patient's chart in hand, but the receptionist can tell the patient when to expect the physician's call.

Of course, in order for the physician to return a patient's call, he or she must know exactly why the patient called. "Do take accurate messages," says Hecht, adding that "I would also suggest buying a telephone log — which you can pick up at any business supply store — which is a book for taking messages. It gives you three copies," which can be saved for later use.

Patient Handbooks

You're new in town, just establishing your practice. Things aren't exactly *slow*, per se, but you would like to increase your patient base. Could a patient information booklet be of help?

In most cases, yes, says Hecht. Hecht was in Columbus recently to conduct a seminar entitled "Starting Your Practice." "It's simply your practice brochure, and for family practice, I think it's a necessity," says Hecht. "For a surgeon, no. For an OB/Gyn, maybe yes, maybe no" — it depends on the specialty and the services you perform.

If you do decide to put together a patient information booklet, ideally it should include the following:

- A description of your specialty
- The types of problems you handle
- Your office staff (but don't mention names)
- Patient visit hours, emergency phone numbers
- Insurance policies ("But only if you don't expect them to change," warns Hecht)
- A map to the office

Hecht recommends avoiding mentioning fees "because they're likely to change" and to do the same concerning when patients can expect lab results.

If you're unsure of your ability to put the text together, Hecht suggests considering hiring a journalism student from a local college, who will typically charge about \$10-\$15 an hour. And make sure you work with your writer, he warns. "This should be a friendly handbook. And use the third person — 'You can find our office . . .'"

The same rules apply when

hiring a printer, Hecht says. "Talk to the printer before you go through with the design. Will it be mailed to patients? Handed out? It's a really good idea for physicians to consider this."

Above all, Hecht says, physicians need to remember that patient information booklets "should be neat, professional, the print should be large — about 10 to 12 points — but it doesn't have to be spectacular."

Physicians may also want to consider publishing a patient newsletter, which, according to some experts, can boost a patient roster by at least 5%.

Others, however, contend that patient newsletters should be produced regardless of whether the physician is trying to attract new patients. "The best publications," says one, "are the ones designed to educate — to improve communications between a doctor and his patients. You should be putting out a newsletter even if you don't need to build your practice."

Generally, patient newsletters should include short articles about advances in the diagnosis and treatment of disease, seasonal health problems (hay fever, frostbite), and the services you offer.

As with patient information brochures, you may want to enlist the help of a local college journalism student to write the newsletter, although some experts suggest the physician (or staff member) write the newsletter himself or herself and hire a professional to edit the material (which is usually considerably cheaper than hiring a professional writer).

As for design, again the general
Continued on page 180

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NEW YORK, WESTERN — Seeking primary care trained physicians for full-time emergency department positions. Moderate volume. Attractive hourly compensation, plus malpractice insurance. Benefit package available to full-time physicians. Director position available. Contact: Emergency Consultants, Inc., 2240 S. Airport Rd., Room 26, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

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PRIVATE PRACTICE OPPORTUNITY — Exists in northwest Ohio, affiliated with a 50-bed county hospital. Twenty years old, very large practice involving general surgery and family practice. Position available immediately due to illness. Competitive compensation package plan and partnership arrangement available. Will introduce, and possible sale of practice in six months. Interested party please send curriculum vitae, references and other pertinent information regarding availability and Ohio licensure to Box 231, c/o OHIO Medicine, 1500 Lake Shore Dr., Columbus, OH 43204-3824.

PSYCHIATRIST — Immediate opening for staff psychiatrists, full-time and part-time, Board-eligible/Board-certified, in a JCAH-accredited, 300-bed inpatient psychiatric hospital. Multi-discipline approach with psychiatrist as a treatment team leader, expected to exercise strong leadership in quality care of patients. Programs for admissions, extended care, geriatrics and psychiatric rehabilitation. License to practice in the state of Ohio is required. Excellent salary and fringe benefits, including paid vacation and personal leave, sick and educational leave, health, vision, dental and life insurance, and Public Employees' Retirement System. Contracts are available. Travel costs may be negotiated. EEO Employer, M/F/H. Send resume to W.J. Roberts, Director of Personnel, or Nathanael Sidharta, MD, Medical Director, Box 540, Massillon, OH 44648 or call (216) 833-3135, ext. 223 or 229.

Continued on page 219

COMMITTED TO EXCELLENCE



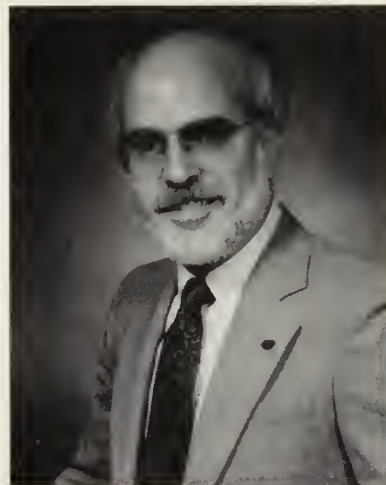
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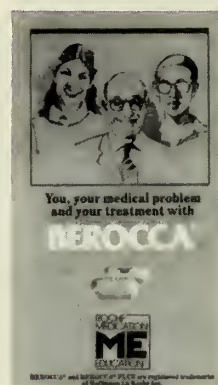


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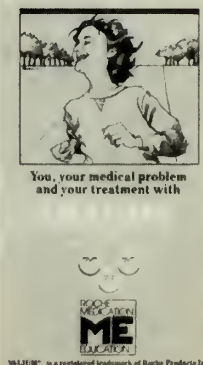
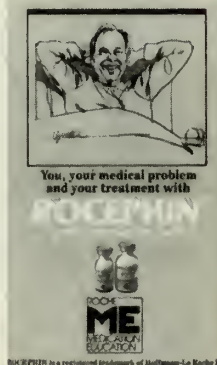
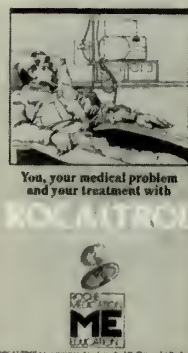
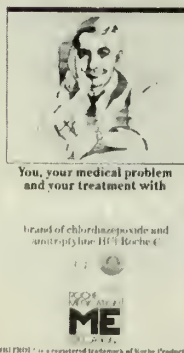
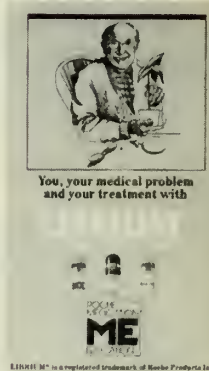
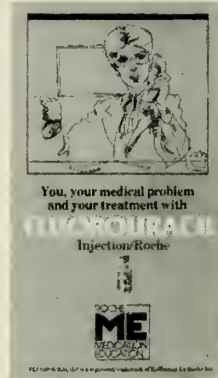
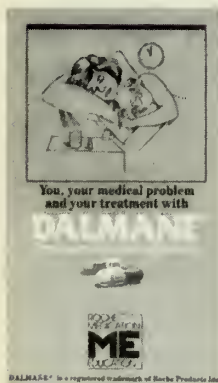


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Medical Salad . . . continued

if anything is to be accomplished. The administrative staff is there to carry out the will of the membership, but the membership has to provide direction for the administrative staff.

To complain that the American Medical Association, the Ohio State Medical Association, the county, local or specialty society is doing nothing accomplishes little. For those who feel this is the case, I offer the suggestion that they become involved to see what their contribution accomplishes. Involvement enriches the salad. Let us look to the future with an enriched salad. *Bon appetit.* OSMA

Edmond Gardner, MD, practices in Columbus.

Continuing Medical Education

Columbus

Critical Care

"Annual Critical Care Symposium," April 19, Hyatt on Capitol Square. Sponsored by Riverside Methodist Hospitals' Critical Care Department. For information: 614-261-5468 or 1-800-257-3900.

Interprofessional

"Women and Children at Risk: Interprofessional Perspectives on the Impact of Substance Abuse During Pregnancy," April 19, Ramada University Hotel. Sponsored by the Commission of Interprofessional Education and Practice. Fee: \$75. For information: 614-292-5621.

Vascular Surgery

"Vascular Disease: A Powerful Response." The 1991 Annual Vascular Symposium, April 26-27, St. Anthony Medical Center, Wallace Auditorium, 1492 E. Broad St. Sponsored by Vascular Surgeons of Central Ohio, Inc., and Saint Anthony Medical Center. Fee: \$100. Category I CME credit hours: 12. For information: 614-253-2731.

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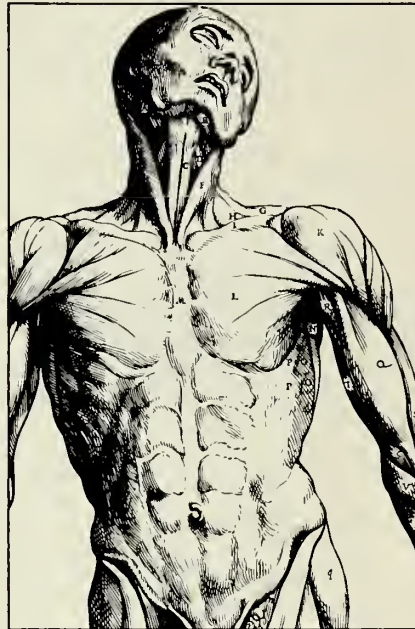
Pediatrics

"Eleventh Annual Pediatric Update" for the practicing physician. April 17, Meshel Conference Center, Northeastern Ohio Universities College of Medicine campus, Rootstown. Sponsored by Children's Hospital Medical Center of Akron and the Ohio Chapter/AAP. For information: 216-379-8906.

Cincinnati

Cancer

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Cincinnati Cancer Symposium." The Comprehensive Management of Recurrent Colorectal Cancer, April 25-26, Piatt Park Conference Center, Cincinnati. Sponsored by the University of Cincinnati Hospital. Fees: \$275 for MDs; \$125 for house officers. Category I CME credit hours: 16. For information, 513-558-4994.

Cleveland

Psychiatry

"Application of Psychoanalytic Principles to Psychiatric Evaluation and Treatment," April 3. Sponsored by the Cleveland Psychoanalytic Institute. For information: 216-229-5959.

AIDS

"Fourth Annual Update on AIDS," May 1, Cleveland Convention Center. Sponsored by the Cleveland Clinic Educational Foundation. Fee: \$100 for MDs; \$75 for medical students. For information: 216-444-5696.

Pulmonary

"Pulmonary and Critical Care Medicine Symposium," April 18-19, Bunts Auditorium, Cleveland Clinic. Sponsored by the Cleveland Clinic Educational Foundation. Fee: \$220 for MDs, \$175 for medical students. Category I CME credits available: 15 hours. For information: 216-444-5696, local, or 1-800-762-8173, other.

Pathology

"Surgical Pathology Symposium," April 27, Bunts Auditorium, Cleveland Clinic. Sponsored by the Cleveland Clinic Educational Foundation. Fee: \$100 for MDs; \$75 for medical students. Category I CME credits available: 5.5 hours. For information, 216-444-5696, local, or 1-800-762-8173, other.

Surgery

"Problems and Techniques in Hepatobiliary, Pancreatic, Portal Hypertension Surgery," April 26-26, Bunts Auditorium, Cleveland Clinic. Sponsored by the Cleveland Clinic Educational Foundation. Fee: \$260 for MDs; \$190 for medical students. Category I CME credits available: 12 hours. For information, 216-444-5696 or 1-800-762-8173.

If you have a program or seminar you wish to have listed, and it is being sponsored by an Ohio-based facility, send all pertinent information to: CME Editor, OHIO Medicine, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824.

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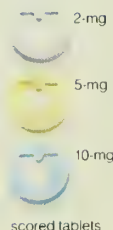
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MAY 1991

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The Trellis by Gustave Courbet

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COVER STORY

Gustave Courbet was one of the most important artists of the last century. He was an inspiration to the Impressionists in his vigorous stand against the art world establishment. *The Trellis* is an important work by Courbet. The carefully modeled girl and brilliantly colored flowers create a pleasant image.

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Farewell and Thanks

FINAL THOUGHTS ON AN INVIGORATING YEAR

John Barrymore said you do not know how short a month is 'til you start paying alimony. He never had to write a column. It doesn't seem possible

this is my last. It has certainly not been a dull year. The crumbling of the Berlin Wall and the reunification of Germany; the hope of a better life for Eastern Europe; the further decline of the Soviet Union with

its surge of the desire for self-government; the changes in South Africa; and the unbelievable 100-hour war that surprised and thrilled everyone with its speed and the unbelievably small number of Coalition-American casualties. As we bask in the euphoria of pride, patriotism and panache, it is hard to get excited about problems that are real, pressing and worsening at home.

We have barked that we want a

place at the table — well, we've got it. Speaker of the House Vern Riffe has appointed a select committee of the House to receive at least seven bills directed to the problems of access and cost of health care in Ohio. Speaker Pro Tem Barney Quilter of Toledo is chairperson. This underlines the importance that the subject carries, and it also means almost certainly some legislation will be passed. In his opening remarks, Chairperson Quilter twice referred to a need to provide basic health-care coverage to the people of Ohio.

Health director Kilroy has been designated by Gov. Voinovich to serve as his facilitator in trying to achieve a consensus, and he has been working with doctors, hospitals, insurers, consumers and other interest groups. We are lucky to have a knowledgeable doctor in that chair. You will be hearing a great deal more as time goes on about this committee, however you may wish to learn who the members of this select committee are and keep yourself abreast of their activities, providing input when and where it is appropriate to do so.

One of the more interesting aspects of this job is that of sitting on the Board of PICO. A job that requires me to bring the members' interests and perspective to the table while maintaining a fiduciary interest in the well-being of a publicly held stock company. Some

By John A.
Devany, MD

President of
the OSMA



Presidential Perspectives

pundit once said that reporting is a combination of rumor, innuendo, back-biting, anonymous informants and hard work. The same can certainly be said about the malpractice insurance market in Ohio. Talk about competition! Fifteen years ago, OSMA was forced to form PICO to guarantee the availability of liability insurance for our members. Now, the market is flooded with carriers. PICO is still working hard at providing good coverage under difficult market conditions.

Several times over the year, I have reminded our younger members that there are wolves in those woods. Now, we have a big one called the National Practitioner Data Bank, which requires the reporting of the first dollar paid in your name for any kind of a patient settlement. This can be a tremendous problem — particularly for those physicians who have no control over their referral base. Usually, these people are dealing with critically ill patients with complicated problems that predispose them to untoward incidents — exposing everyone who has passed the patient in the halls to being named in a suit. Traditionally, many of those are called nuisance suits. They are frequently settled for relatively small amounts, and the settlement is pro-rated through the listed physicians, and are now reported to the data bank.

I would encourage each physician to look carefully at what rights they have in determining when a suit is settled in your name. Unlike other companies that will settle cases without your consent, PICO allows you to determine whether the case will be tried. These consent provisions, plus an occurrence policy, do cost more, but sleep can be expensive,

and bargains are not always bargains.

Your Council has also been vigorously looking at the long-range prospects for this organization. Think how the demographics of medicine have drastically changed even in the short time I have been in it (35 years). Then, practically everyone joined (some percentage of doctors join nothing), but no one will deny this was pretty much an “old boys” club. No way is that true today. At national meetings, marketing is the hot topic. This is because the average member is scrutinizing dues much more carefully and looking at membership as an investment, not a professional obligation. This isn’t bad — it’s just a fact. We all have to allocate our resources, and associations are no different. Financial and human potential and resources can’t be wasted. So each service must be practical and directly attentive to member needs.

One meeting I attended pointed out how, in volunteer organizations, it is very hard to discard outdated activities because the volunteer leadership has pride of authorship. It was said past presidents are notorious for impeding the purging process. I promise I shall not. You will hear more of this planning as it goes on. Check with your councilors and give him or her your help and advice.

I leave this position safe in the knowledge that we have Joe Sudimack, MD, who knows the job and is ready to step in. Joe, there will be days when everything goes your way. Don’t worry, it won’t last. The only hard part of this job is shaving twice a day.

Those of us who were in the service remember the Efficiency Report and the last question,

“Would you prefer to have this officer in your immediate command?” It is said of then colonel George Marshall that he had such a manner and presence and such people smarts, a senior officer once wrote it would be a pleasure to serve under his command. The only person at OSMA that the president supervises directly is executive director Herb Gillen. I can think of no better description than he is one damn fine colonel. Herb, I salute you.

In her first page this year, Auxiliary President Sue Massie outlined her personal philosophy. It said: “If we go through life and the world is not better for our having been a part of it, we have missed a wonderful opportunity.” I have had the wonderful opportunity of working with this energetic and gracious lady who has performed her job so beautifully throughout the year. I enjoyed serving with her, and I believe the OSMA, if not the world, is better for her having been a part of it. I also wish to publicly and profusely thank my partners and their wives for their help, support, good humor and, in the face of inconvenience, their coverage and their prayers.

We have a great group. It has been an invigorating experience to be president. I thank you for your support. May God keep you in the palm of His hand. **OSMA**

Strategic Planning

PUTTING OUR "PATRIOTS" INTO PLACE

Everyone is ecstatic about the recent victory in the Persian Gulf — and rightly so. It was a tremendous victory, and

particularly awesome because of the fact that it was perfectly executed and the casualty loss was so low. It was record-setting in many ways.

But what might the outcome have been if someone had

not had the foresight to develop the Patriot missile? Not only would the outcome have been different, but also the destruction of lives and property by the Scud missiles would have been devastating. To what can we attribute this success in the Persian Gulf? Strategic planning!

The Ohio State Medical Association acknowledged the need for sound strategic planning and brought a professional long-range planning consultant to the OSMA Council's two-day meeting recently

in Columbus. Members examined the current status of the organization, its strengths and weaknesses, and made projections for a healthy future.

There is pessimism regarding the effectiveness of all groups allied with medicine today because of the dramatic changes in government regulations and in reimbursement for services. Women will become a much more visible and viable part of the association; physicians are retiring much earlier; young physicians will soon need to be assuming roles of leadership in the organization; and private practitioners will be replaced by group practices. Medicine has become increasingly technology-oriented versus the "art of medicine" earlier practiced.

All of these factors affect the manner in which an organized group can be of service to its members. How we plan for the future will determine the place the medical community will hold. The Ohio State Medical Association is making real efforts to see that the needs of Ohio physicians are met and will continue to be met in the future.

Risks are a part of preparing for positive change and growth; and how our time and money are spent today will determine the viability of medicine in the future. It is certainly gratifying to see that the OSMA is ready and willing to meet the challenges facing the profession in a positive and

Continued on page 255

By Sue Massie

**OSMA Auxiliary
President**



Letters to the Editor

AIDS and insurer discretion

To the Editor:

I saw an article from your December 1990 issue titled "Health Insurance-Between the Lines" by David L. Weldy, MD, PhD. Dr. Weldy's article discusses a release form that he was asked to sign when he applied for health insurance where blood testing was requested by the insurer.

A newer form of release is now used in at least 20 states at the suggestion of insurers.

If Dr. Weldy had seen this newer type of release, he would know that if an insurer receives a triple positive HIV antibody test result, then the insurer will submit a generic or general code to the Medical Information Bureau (MIB), which merely indicates an abnormal finding on a blood test. Therefore, MIB does not know whether an applicant for insurance tested positive for AIDS virus antibodies. Test results for 23 different blood abnormalities are reported under the generic/general code for abnormal blood tests; only one of those 23 test results refers to HIV testing. If an insurer subsequently receives the MIB report as an alert against fraud, that second insurer will request that a blood sample be submitted for 20 to 30 (or more) tests, which would include HIV testing. Testing or other forms of investigation by the second insurer will define the basis for the general code.

Dr. Weldy and your readers should also know that MIB does not have a report on most people who apply for individual policies of life or health insurance. Of 10 applicants, MIB will have a record of one or two who have significant health or other risks. Also, any reports more than seven years old are automatically eliminated by

computer edit.

For over 90 years, the basic purpose of MIB has been to make it much more difficult for applicants to conceal or omit significant information.

Neil Day

President

Medical Information Bureau
Westwood, Massachusetts



Electronic claims filing not without cost

To the Editor:

In response to the recent article "Filing Medicare Claims Electronically," I would like to point out that if a physician has only one or two Medicare patients a year, as the article suggested, it would be quite costly to file electronically. Using the figures in the article, the cost of filing those one to two claims would range

from \$725 to \$1,200 per claim, which is certainly a far greater cost than the average office visit.

When physicians file claims electronically, Medicare realizes quite a cost savings in claim processing. There are several advantages. Payment is faster and there is less chance of code changes by Medicare examiners. On the other hand, there are also disadvantages. The article assumes all physicians already have a computer and printer, but for those who do not own a computer, the cost of filing that claim has now increased significantly. Other disadvantages include the initial training period, employee turnover, and retraining. As was noted in the article, other insurance companies may not use the same electronic format for filing claims. This could require additional expense for the proper equipment.

Medicare has again presented the medical community with the golden apple, under the guise of how much it will benefit the physician, while in reality the greater benefit will be realized by Medicare. By showing how much better electronic filing works over the hard copy system, we are offered a bite of the golden apple. This may be so, but it is not without a price. Let us not be blinded by the short term sweetness that may be bitter at the core. To jump into this system thinking all our payment problems with Medicare are over is naive. New problems will be created. While electronic claim filing is faster for most claims, some claims will still need to be filed by hand. Before jumping on the Medicare bandwagon, we should make sure that the benefits outweigh the cost. Those in large group practices may realize a significant benefit, but those in small solo practices could be looking at a significant increase in

Letters to the Editor

practice expenses, while realizing only a small gain. In these days of cost containment, we must look for ways to keep medical costs down, not only for Medicare, but also in our practices.

Edmond W. Gardner, MD
Columbus

A vote for more clinical

To the Editor:

I surely am going to miss the format of our journal, which was thought to be appropriate in the past. While I can agree that perhaps some of the articles that have been published would not have made it into *The New England Journal of Medicine*, I, quite frankly, enjoyed them more than those devoted to socio-economic topics.

Also, it provided us with a great deal of information about personalities in Ohio medicine, particularly those who are transient in leadership roles at the state level and whom we would never have known anything about otherwise. I gather you hope to continue something of that order.

I am sure that financing had a great deal to do with downsizing the journal, but I, for one, think that it is important enough to intersociety relationships that it should be continued in its previous format. Many of us have often wondered what OSMA really means to us, and what it really does for us. I do not think that this journalistic decision represents a positive move, although I am sure your committee has spent a great deal of time researching and discussing the problems with the journal.

I am the editor or co-editor of a number of specialty journals,

and so, in a sense, I am raising a professional opinion against the changes.

Robert J. White, MD, PhD
Cleveland

Concerned with bylaws changes

To the Editor:

I have concerns about three of the proposed changes to the OSMA Constitution Article I:

1. While we are retaining as one of the purposes of our association encouragement of interchange of information of medical science, I believe damage will occur at least to our image as well as the profession if we delete as one of our purposes for existence old items 4 and 5, whether on the basis that it is not one of our priorities or simply because we don't provide such service, particularly in light of the fact that these were the original goals in founding the AMA. Expediency does not negate the validity of these items.
2. While I can see the argument of the deletion of "strict" and "highest" in old item 6 on the basis of semantics, I am concerned that given the other proposed changes in this article, some may interpret these deletions as signifying that adherence to professional ethics should be based purely on personal preference/whims, or that we are willing to accept something less than the highest concepts of professional ethics. I don't believe we can afford to risk such an image, and semantic correctness certainly is not worth such an exposure.
3. New item 6 could easily be

interpreted as the conversion of our association to a professional lobby group, particularly when taken in conjunction with the other changes above, and in my opinion would only confirm what our critics have accused — that we are in fact no different than a trade union with a primary purpose of protecting the members of our organization to the neglect of promoting and protecting quality standards of care for society.

I for one am not willing to change our association to make it equal to all other associations representing vested-interest groups if that equalization is obtained at the expense of compromise in any of our professional standards. Perhaps it is time to concentrate on those professional standards rather than our present obsession with pecuniary stability.

Jon E. Starr, MD
Columbus

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Health Care's Future

HOW TO HANDLE A WORLD GONE TILT

By Richard J.
Nowak, MD



admissions, CPT coding, length of stay constraints, MAACs and DRGs are only a few requirements. There is no question that in the near future many dramatic changes will take place in the practice of medicine.

There are many interlopers in the traditional physician-patient relationship who are attempting to control cost. In the beginning, third-party payors were the only kids on the block. Now, the politicians and health benefit executives of business have become

In the past decade there have been many revolutionary changes in the health-care field. Even in the past couple years radical changes have been evolving. Precertification for hospital

involved. In addition, there are numerous pseudo-health-care providers emerging in the practice of medicine. This adds to a mixed bag of confusion and complications in regard to the quality and cost of health care.

About 30 years ago, union leaders unwittingly began conditioning their members toward prepaid medical care. Instead of raises in wages, medical care was bargained as a benefit. At that time, this had an attractive appeal to both the workers and employers.

When Medicare came along, the ground work for a pre-paid government system for the elderly was laid down. Now, cuts in Medicare payments are needed to help in reducing the federal budget deficit.

In the meantime managed health care has made inroads into the delivery of medical care. There is no doubt that the cost of medical care will not continue as a blank check. This mentality will cease. Health-care costs have become a top concern of American business leaders.

An annual health costs survey by A. Foster Higgins & Co. shows that corporate medical bills soared 21.6% in 1990 and amounted to 26% of corporate earnings. Overall health-care costs will continue to rise in 1991. This is evidenced by

From Our Editors

the increasing use of advanced medical technology, aging of society, and cost-shifting from government to the private sector.

Consequently, employers are looking into managed health-care programs to control costs. This translates into medical expense management, improved utilization of medical services and contracting with health-care providers.

The Conference Board, a New York-based organization that does research on economics and management issues, surveyed 600 chief executive officers representing all types of industries. They found that out of 16 serious economic problems, 89.9% of the CEOs said health-care costs will place a serious burden on the nation's economy during the 1990s. Only 1.6% said it was not a serious concern and 8.5% took the middle ground. The federal budget deficit marked a close second among CEOs at 89.2%. The third top concern was the savings and loan crisis at 81.6%. This survey was reported in November 1990, prior to the onset of the Persian Gulf War. In the coming year another survey may be forthcoming.

As one looks over the horizon into a crystal ball and tries to evaluate the demands for quality medical care that is cost efficient, the principal people around the negotiation table are executives of corporate business and politicians from government.

According to Healthcare Forum, a national panel, in a recent "Future Tract" survey, it is predicted that managed health care will cover more than half the population by 1995. Today about 25% of all Americans are members of managed health-care plans. Standard HMOs are growing at a 3.6% annual rate. Open-ended plans grew 39% last year.

Indications are that if physicians

An annual health costs survey by A. Foster Higgins & Co. shows that corporate medical bills soared 21.6% in 1990 and amounted to 26% of corporate earnings. Overall health-care costs will continue to rise in 1991.

do not face their responsibilities to provide solutions to health-care costs, then Uncle Sam will take over. Some unions favor a national health plan, and the corporate business world is tilting. Physicians must come to grips with the cost of health care and must monitor

medical practice behavior. The best medical care can be cost effective. **OSMA**

Richard J. Nowak, MD, is a member of the OHIO Medicine Advisory Committee.

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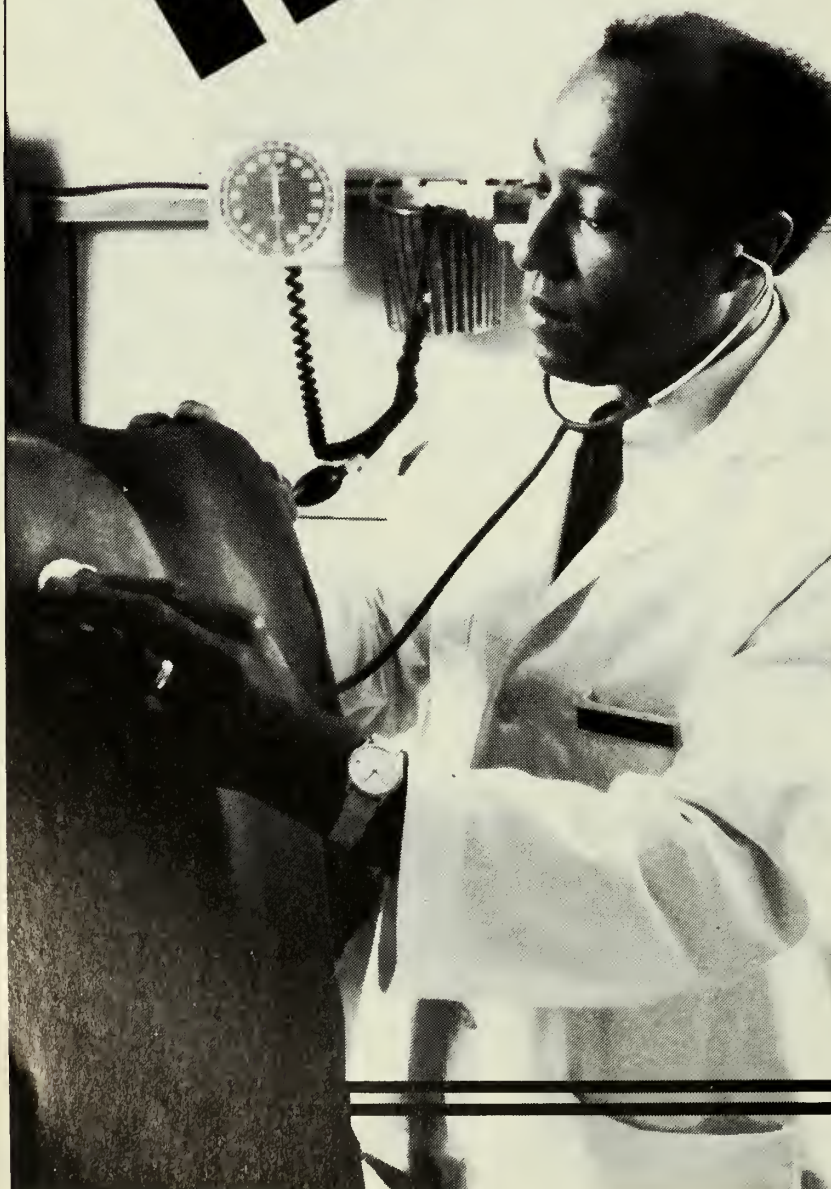
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The Risks of Quality Assurance

COMMITTEES MAY BE TICKING TIME BOMBS

The term "quality assurance committee" is used in lieu of all forms of hospital quality assurance functions.

The quality assurance committee (QAC) that acts capriciously and

irrationally needs guidelines or it will face liability instead of the immunity conferred on it by the Health Care Quality Improvement Act (HQIA), approved by Congress in 1986.

The Health Care Finance Administration's (HCFA) Third Scope of Work in 1989 established the Quality Intervention Program (QIP) and its "point system," which triggers intervention with providers when quality concerns are identified.

The point system provides specific guidelines that quality assurance committees should adopt.

Some advantages for adopting the point system include:

1. It is an established dogma/code/doctrine/tenet.
2. It is a national standard,

governing the quality of care of every practicing physician.

3. It is understandable.

4. It is reasonable.

5. It is consistent with HCFA's goals of improving the quality and lowering the cost of health care.

Improving the quality and lowering the cost of health care should be one of the goals of the quality assurance committee. Education should be the other. By adopting HCFA's point system, the quality assurance committee addresses both goals locally, where *education* instead of punitive action can be implemented and emphasized. The quality assurance committee should reinforce education of the physician-provider by stressing familiarity of the QIP point system, as well as supplying current medical references and clinical data to support the quality assurance committee's decisions when it is conferring severity levels I, II or III on colleagues.

Furthermore, the quality assurance committee allows rebuttal by the faulted physician. On the other hand, those PROs that utilize the QIP point system allow no reconsideration of quality decisions. The quality assurance committee has a unique opportunity to build esprit de corps among colleagues and reinforce physician-hospital relations. Hospital administrators should give high priority to this



By Emerson
L. Laird, MD

Second Opinion

opportunity, which means they will have to increase budget for both educational personnel and facilities.

The cascade of physician conformity flows from HCFA to the state PROs to the quality assurance committee. This is the common pathway from HCFA into the physician provider's plan of care. Physician education, via the quality assurance committee, can modify reflex physician practice patterns and decisions and make them consistent with goals of HCFA and the PRO's standard of care which, in turn, may avert punitive actions against colleagues by the PROs.

The quality assurance committee has an obligation to the profession to intervene when quality concerns are identified. That obligation includes teaching them the art according to Hippocrates. According to the QIP point system, the only alternatives beyond education are punitive.

Since providers must abide by the law, education is the best defense with which the physician and hospital can meet the challenge.

Utilization, the only other PRO function, has been successfully challenged. The Illinois Society of Internal Medicine reversed 29 of 30 (96.6%) PRO utilization denials!

Since indiscriminate, capricious and irrational decisions of quality assurance committees exist, quality assurance committee reviewers cannot expect to go unchallenged.

A federal court has confirmed that doctors are shielded from retaliatory suits *if* they follow certain guidelines. Since the QIP point system *is* a guideline every physician lives with, that guideline merits adoption and reinforcement by the quality assurance committee. Guidelines beyond the QIP point system are less well defined and beyond the expertise of physician-reviewers and hospital

Your liability under Ohio law

According to the OSMA's "Physicians Guide to Ohio Law," compiled by the Department of Legal Services, there are three statutes in the Ohio Revised Code (ORC) that refer specifically to peer review committees.

ORC 2305.25 — States that no individual who is a member or employee of a utilization review committee shall be liable for any decisions made within the scope of the functions of such committee. Also, no person who provides information under this section — without malice and in the belief such information is warranted by the facts — shall be subject to suit for civil damages.

ORC 2305.24 — States that information available to the committee is confidential and a right of action shall accrue against a member who misuses that information.

ORC 2305.251 — States that no person may be required to testify to matters or evidence presented at a committee meeting. Contact the OSMA Department of Legal Services for more information. **OSMA**

administrators. Legal counsel should be available at all quality assurance committee meetings when severity levels I, II or III are considered, and always consulted when points are to be conferred upon a colleague.

Peer Review actions will not constitute serious anti-trust suits as long as fair procedures are followed according to California Medical Association attorney Elizabeth A. Snelson.

However, keep in mind that what *seemed* to be fair procedures to five peer review physicians in Santa Barbara, California, has

resulted in \$400,000 in legal fees, and an appeal filed against them in the United States Ninth Circuit Court of Appeals.

Therefore, quality assurance committee members should be reassured by the hospital administration that quality assurance is an acknowledged hospital function and that any liability incurred by the peer reviewer is covered by the hospital's insurance carrier.

HCFA's lofty goals of improving the quality and lowering the cost of health care cannot be mandated. Quality starts with education in the trenches, but quality also risks being compromised by cost control. Cost is relative. Vouchers could assure quality for discriminating Medicare and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) patients, who prefer to escape "the system" to acquire definitive comprehensive health care that they perceive as quality care.

Meanwhile, the public is better served by the quality assurance committee that adopts the QIP point system, assumes an educational posture and confers severity levels I, II or III with legal counsel. The public would be best served if the health-care system provided vouchers as an alternative to health-care compromised by cost control. **OSMA**

Emerson L. Laird, MD, practices internal medicine in Mt. Vernon.

The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of OHIO Medicine or the Ohio State Medical Association.

Ohio Medi-Scene

Workers' Comp Bureau hopes to speed MD pay

The state's Bureau of Workers' Compensation has proposed measures that it hopes will enable it to provide better and faster service to injured workers, as well as improve the pace at which physicians are compensated.

The measures include issuing insurance identification cards to injured workers, much the way private insurance companies do, and paying biweekly benefits electronically or giving workers magnetic bank cards they can use to collect their benefits.

The bureau has had problems in the past establishing a claim number for those injured on the job or who suffer from a work-related illness. Bureaucracy is one of the reasons for these problems, but another is that employers are remiss about reporting injuries and illnesses promptly.

Under the proposed system, an injured worker's social security number would be the base of a claim number. That number, plus the medical codes for the injury or illness would be put on the identification card with, perhaps, the date of the injury. The worker would show the card to a doctor as proof that an approved claim file exists. The doctor would know what injury the bureau would pay to treat, so the physician's bill would be accurate when submitted for payment and less likely to be held or rejected for technical reasons.

Most of the 8,500 new claimants that the bureau hears from each month would receive a medical card because their treatment is likely to be long-term.

For those receiving job-loss benefits, the bureau wants to be able to deposit the money electronically into their bank accounts every two weeks. For claimants without bank accounts,

the bureau hopes to establish accounts from which they could collect benefits by using magnetic cards.

An education program, urging employers to report illnesses or injuries promptly, is also being planned. **OSMA**



Ohio students don't worry about AIDS

Ohio college students still believe that they are invulnerable to AIDS, and are taking few if any precautions to guard against possible infection, says a report from Bowling Green State University's Department of Medical Technology. The report was published in a recent issue of the *Ohio Journal of Science*.

According to the 1988 study, almost 74% of the first-year

college students interviewed said that they had sexual intercourse by their 17th birthday, but fewer than 8% of these students believed their chance of contracting AIDS was medium to high.

"They think that, because they're in middle America, they'll never be touched by this," says researcher Judy L. Adams.

In addition, about 70% of the sexually active respondents reported a total of one to three sexual partners, and 15% reported three or more partners within the last year.

"It is not just experimentation," Adams continues. "It is a matter of serious involvement, sexually, with many different individuals, and that's where the crux of the problem is."

At least 56% of the students claim to have modified their sexual activity because of the threat of AIDS, but 44% reported no change. With regard to condom use, 27% of the students reported always using a condom, while a total of 17% said they never used one. **OSMA**

Cincinnati lags in AIDS cases

Cincinnati is behind other larger metropolitan areas in the number of AIDS cases, and local health officials think this might work in their favor for fighting the disease.

"Since the onset of the illness hit us later, it means that what the larger metropolitan areas are seeing (now) is going to hit us later," Tina Roberts, planning director for the Greater Cincinnati AIDS Task Force, said. According to Roberts, the East and West coasts didn't have time to prepare for the AIDS outbreak — it just came up. She hopes that Cincinnati can learn from all of this.

Ohio Medi-Scene

A 40-page report was recently released with a plan for combating AIDS locally. It predicts the number of AIDS/HIV cases will increase gradually, particularly in blacks and women, the two groups among whom cases are on the rise nationally.

Education programs to eliminate anti-homosexual prejudice and an annual survey of doctors and dentists willing to treat people with AIDS/HIV are also called for in the report.

The number of people diagnosed with AIDS in Greater Cincinnati is 565; this projection is based on the number of cases confirmed in the first six months of 1990, according to the task force. That figure is up from 395 total cases in 1989.

AIDS is no longer a disease exclusively associated with white homosexual males. AIDS is increasing in blacks and women. As of the end of 1988, 16% of local confirmed AIDS patients were black. As of August 1990, it was 21%. The number of female patients is estimated at nearly 100 for 1990, up from six in 1986, 39 in 1988 and 62 in 1989.

The task force feels this research will help all people involved in caring for those with AIDS. According to Roberts the information in the report will get individuals to think about what's ahead. What will we need next year? Or the year after? **OSMA**

AIDS
Awareness Week
May 4-10



New cancer drug tested in Columbus

Grant Medical Center in Columbus is testing a new cancer drug that will help those patients with resistant lung and breast cancers.

The new drug, Navelbine, looks promising because of its ability to reduce tumors without causing some of the side effects of chemotherapy.

Navelbine has been used in France where one out of three patients with lung cancer showed signs of tumors shrinking by more than half.

The outcome of the trials at Grant and elsewhere will determine whether Navelbine is approved by the Food and Drug Administration for general use in the United States. **OSMA**

Appeal to stop RX search fails

The Summit County Medical Society suffered a second setback when the Ninth District Court of Appeals refused to bar police from checking pharmacy records for evidence of narcotics abuse. The court upheld a Summit County Common Pleas Court ruling that determined the police action was legal.

A group of local doctors, patients and a pharmacist, with the support of the Summit County Medical Society and the OSMA, sued the police after learning that law enforcement officers in six communities — Stowe, Munroe Falls, Tallmadge, Mogadore, Hudson Township and the village of Hudson — began collecting pharmacy records in July 1988. The information on the records (which are obtained without a

search warrant) is used to locate people who obtain prescriptions for narcotics from several doctors, or to find doctors who prescribe suspiciously large quantities of narcotic drugs.

The Court of Appeals ruling said, in part, "we find no legitimate expectation of privacy that would prevent disclosure of prescription information to health officials and police officers of the present context." **OSMA**

Prices rise for Ohio medical insurance

Medical insurance costs for employees in the state rose an average of 24.8% last year, according to a study that surveyed 151 employers in Ohio.

The survey, conducted by the A. Foster Higgins & Co. employee

Ohio Medi-Scene

benefits consulting company, showed that the costs increased from an average of \$2,638 to \$3,292.

Nationally, costs increased from an average of \$2,600 to \$3,161 or 21.6%.

The state survey showed that 99% of the employers who responded ranked medical cost containment as their number one health benefit issue facing them in the next three years. All but 6% of the respondents indicated that sharing increased costs with employees would be a part of their corporate strategy. **OSMA**

Medicare project begins at Columbus hospital

Ohio State University Hospitals in Columbus is one of four hospitals across the country that has been selected to participate in a government effort to tackle soaring Medicare costs by setting flat fees for bypass surgery.

OSU Hospitals will join St. Joseph Mercy Hospital in Ann Arbor, Michigan; St. Joseph's Hospital in Atlanta; and University Hospital in Boston.

This project will present a total fee for coronary bypass surgery instead of setting separate costs for hospitals, physicians and others.

In 1991, Medicare will pay more than \$3 billion nationally for hospital and surgeon fees for more than 135,000 coronary bypass patients.

The U.S. Health and Human Services Department expects a savings of between 6% and 30% at the hospitals. An OSU Hospitals official reports that OSU should save 20% to 30%.

The project is expected to run

for three years. If it is successful, similar pricing may be applied for other Medicare-paid operations. **OSMA**

Lorain County Medical Society begins foundation

The Lorain County Medical Society plans to move to its own building this summer, then, once settled, it will rent out office space to other businesses to generate income for its newly formed foundation.

"The building is going to be the workhorse to generate income for the foundation," says Thomas Martin, MD, president of the society.

Office rentals in the new building are expected to contribute up to \$40,000, although Dr. Martin says the potential, in the future, may allow the fund to grow to the half-million to million-dollar range. At least 8% of the fund will go toward charitable organizations in Lorain County.

The new \$350,000 headquarters building, slated for a mid-summer completion, will be located north of Lorain County Community College on North Abbe Road. **OSMA**



Bad and good news about Ohio's children

During the 1980s, Ohio improved its infant mortality and child death rate, and its rate of violent death for teens was the fifth lowest in the country. However, the rate of increase of unwed teens giving birth in the state was 28%, more than double the national increase in this area.

These statistics come from "Kids Count," a statistical portrait conducted by the Center for the Study of Social Policy based in Washington, D.C.

The 86-page report concluded that the previous decade was hard on the nation's children in general.

"Violence and poverty, poor health, teen parenthood and school failure dim the future of millions of children," the report states.

Overall, Ohio ranked 23rd among the 50 states and the District of Columbia on the well-being of children.

"America's fate in the 21st century depends on how we treat our children today," says one of the project's coordinators. "We won't be ready unless we reverse these trends in the 1990s." **OSMA**

Ohio Medi-Scene

Colleagues

James Bazzoli, MD, Marion, has been selected to receive the Lewis W. Hine Award of the National Child Labor Committee. The award was established in 1985 to recognize individuals who have provided services on the behalf of the well-being of children.



Dr. Bazzoli, an obstetrician, was specifically recognized for establishing the Marion Adolescent Pregnancy Program (MAPP) 10 years ago. The program offers prenatal visits, in-home parenting programs and human sexuality courses, which have resulted in an estimated 36% decrease in teenage pregnancies in Marion.

Leland C. Clark, Jr., MD, Cincinnati, who invented the bubble oxygenator, a key element of the first heart-lung machine, is the winner of the 1991 American Heart Association's Samuel Kaplan, MD Visionary Award. Dr. Clark has been professor of research pediatrics at University of Cincinnati College of Medicine/Children's Hospital Research Foundation since 1968. He also invented an electrode used to monitor oxygen levels in the blood.

Ernest W. Johnson, MD, associate dean for external affairs at Ohio State University College of Medicine, has been named a distinguished member of the Association of Academic Physiologists. He is also former chair of the Department of Physical Medicine and Rehabilitation at Ohio State. Johnson founded the association in 1967 to serve as the national organization of physiologists affiliated with medical schools. He is the first person to be given the honor. A distinguished member is a current or former member of the association who has achieved international status and is recognized as a major contributor to the field. As a distinguished member, he is recognized as a lifetime voting member of that organization, and can serve as an officer.

Eugene Saenger, MD, Cincinnati, was honored recently in a special ceremony for his role as a founder of the Society for Medical-Decision Making, at the group's annual meeting in Boston. Dr. Saenger, a professor emeritus of radiology at the UC Medical Center, was among the early pioneers of the group, which is dedicated to promoting rational, systematic approaches to health policy and clinical care of patients. He also served as the group's first president.

Insurers won't pay for smokers who lie

It's not nice to lie to your insurance company, and, according to a ruling in a Philadelphia federal appeals court, it's not legal, either.

Courts have long held that life insurance applicants who lie about their medical histories can have their policies voided — no matter how they die — and the decision by the Third U.S. Circuit Court of Appeals extends this rule to smokers.

The case before the court involved a man who died from AIDS one and a half years after completing an application for a \$50,000 life insurance policy. Because the insured misrepresented his smoking habits, the court said that the insurer, New York Life, need not honor his policy.

The Philadelphia case, which extends the responsibility of stating the truth on insurance policies to smokers, is in line with similar appeals court rulings in Georgia, Maryland and New York. **OSMA**



Ohio Medi-Scene

New hospital unit shortens hospital time, costs

Southern Ohio Medical Center's Mercy Campus, just north of downtown Portsmouth, has set up an experimental unit designed to make the hospital seem more like home.

Modeled after a similar, 11-year-old unit at New York University Medical Center, the unit's goal is to make the patient as independent as possible. Toward that end, each room is furnished with a dinette set to encourage patients to take their meals away from their beds, and family members serve as "care partners," staying around the clock, if they choose, to help the patient walk, bathe and eat. They also change dressings and help monitor changes in the patient's condition.

In addition to speeding recovery time, the 16-bed unit also cut costs for both the hospital and patient.

The new unit, which opened last July, is believed to be the only one of its kind in Ohio, and one of only 13 nationwide. **OSMA**

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St. Luke's Healthcare Association – a progressive, 418-bed multifacility healthcare system located in Saginaw, Michigan – currently has private practice and hospital career opportunities for physicians in selected areas of specialization.

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Michigan State University's College of Human Medicine.

St. Luke's Healthcare Association is a diverse and growing organization, anxious to meet with physicians interested in pursuing a career marked by a strong administration/physician working relationship and a team approach to patient care.

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Research

Exercise during pregnancy

How much, how intensely and how frequently can women safely exercise during pregnancy? Those are the questions that Cleveland obstetrician James F. Clapp, MD is attempting to answer with a four-year study he is conducting at MetroHealth Medical Center.

Although the American College of Obstetricians and Gynecologists issued guidelines on this subject in May 1985, Dr. Clapp believes that women are now much fitter than they were in 1985, and he hopes to create a new scientific framework within which pregnant women can safely exercise.

Dr. Clapp performed similar studies in New Hampshire before coming to Cleveland, and learned there that the impact of exercise on the baby may mean smaller babies, but ones that are healthy and born with less baby-fat. The baby's size, says Dr. Clapp, is directly related to the amount and intensity of exercise of the pregnant mother. **OSMA**

New hope for colorectal patients

New drugs . . .

Physicians at Case Western Reserve University's School of Medicine are continuing their research into colorectal cancer, thanks to a five-year, \$5.5 million grant that came to them from the National Cancer Institute. The medical school researchers hope to find a way to make chemotherapy work for those patients for whom surgery is no longer an option.



The grant will enable researchers to grow colorectal cancer cells in the laboratory and to test experimental drugs on them. Although the work has been experimental so far, five patients have been given one of the first anti-cancer substances the researchers have worked with, in conjunction with heavy doses of Melphalan. It is too early to judge the regimen's effectiveness, however, say the researchers.

They hope to develop drugs that will interfere with the cancer cell's ability to repair the damage done by chemotherapy. Although researchers have identified several such substances that seem to work in cancerous tissue cultures in the laboratory, they hope to find others in the coming years.

And new technology . . .

A Columbus company has

entered the final stage of testing a new technology that will help surgeons identify previously undetected cancerous tumors during surgery.

The Phase III trial will involve approximately 400 colon and rectal cancer patients at 20 medical centers around the country.

The technology, called Radioimmunoguided Surgery (RIG), combines the use of radiolabeled monoclonal antibodies and a gamma detection device to identify cancer tumors that are not detected by existing methods. When suspicious tissue is probed, the instrument emits a siren-like tone, and its control unit displays a numeric count. In previous clinical trials, the information provided by the RIGS system influenced the surgical management of the patient in 35% of the cases. **OSMA**

How to Fight City Hall

LOU BARICH, MD VS.
THE TANNING PARLORS

Louis L. Barich, MD, Hamilton, has preached about the dangers of tanning for years. Then, when three men in his high school graduation class died at an early age of melanoma (there were only

50 in his class), Dr. Barich knew it was time to climb down from his pulpit and get busy.

"Twenty plus years ago, when my friends started dying of skin cancer, I got to wondering about a lot

of things. I realized I couldn't do anything to help them personally, but perhaps I could get involved in an education program that could help others," he explains.

Dr. Barich's involvement grew beyond an educational program, however. Together with other interested physicians, this one-man dynamo succeeded in doing something that no other city in Ohio — perhaps the nation — has been able to do. He succeeded in

changing the tanning parlor regulations in his own community. Suddenly, Hamilton, Ohio was on the health-care map for its tanning parlor ordinance, and Dr. Barich began fielding calls from other communities, inside and outside the state, that wanted to make similar changes in *their* city ordinances.

Last October, the Ohio Dermatological Association recognized Dr. Barich for his achievement by naming him "Ohio Dermatologist of the Year" — the first time such an award has been given. His accomplishments are noteworthy not only to dermatologists, however, but to all physicians who have ever tried to push a camel through the eye of a needle, as most legislative efforts are likened to these days. The story of Dr. Barich and the tanning parlors is more than an illustration of one man's determination and will. It is an example of what physicians, or medicine in the broader sense, can accomplish. To view the history and progress of Dr. Barich's tanning parlor campaign is to understand what organized medicine can (and does) do for medicine.

Background

How does a personal campaign such as this evolve into an issue of such broad scope? It takes a physician who is dedicated to the cause.



Legislation

"In a way, (Dr. Barich) is unusual in the intensity with which he pursued this, and I find that very admirable," says R. Bennett Eppes, MD, immediate past president of the Ohio Dermatological Association.

It was early in 1988 when Dr. Barich brought before the Ohio Dermatological Association a resolution regarding tanning parlor regulation. The resolution passed handily, but Dr. Barich was not content to let it rest there. He wanted the issue to have broader play. There was still time to draft a resolution for the Ohio State Medical Association's House of Delegates, which holds its annual meeting in May. He suggested it to his dermatology colleagues.

"My peers supported me," he recalls now — but the support was conditional. "Lou, you write the resolution — we'll work on it." Dr. Barich sat down and drafted the proposal that became OSMA Amended Resolution 68-88, "Public Education on Hazards of Tanning Parlors." It was quickly adopted by the OSMA House.

From resolution to ordinance

That was spring. There was still a lot of year left and Dr. Barich was anxious not to waste a day of it. During the summer, he spent endless hours traveling throughout the state, publicizing his resolution wherever he could. Did the fact that it now had the blessings of two prestigious medical groups provide him more clout? Undoubtedly, but there is no denying that it was Dr. Barich's missionary-like zeal that brought it to the attention of so many that summer. On one of his frequent trips to Columbus, Dr. Barich paid a visit to the secretary of the Ohio Board of Cosmetology — the position responsible for the regulation of tanning parlors. It was following this discussion that



"My goal was to help Hamilton develop the first tanning parlor ordinance, and then go to the sidelines."

Lou Barich, MD

Dr. Barich decided to come up with a local tanning parlor ordinance.

He contacted a friend, a surgeon, who not only sponsored but spoke on behalf of the legislation before Hamilton's city council.

"We had seven city councilors to convince," says Dr. Barich, and he was reluctant to risk even one no vote. So, he and other physicians

met individually with each council representative.

"We got down to the seventh and last councilor who was a lawyer and who also happened to be the vice mayor," says Dr. Barich. He and four physician friends met with this individual on the second Tuesday in June and performed what's known on the circuit as the "dog and pony show." After reviewing the reams of material, viewing the graphic slide presentation "Skin Cancer Preventable and Curable," and listening to the experts, the vice mayor became one of Dr. Barich's staunchest supporters.

A few days later, on Friday, the city manager approached Dr. Barich and asked if he'd be ready to "go official" with the ordinance by Wednesday evening. The time seemed unforgivingly short, but Dr. Barich set to work. It took some quick phone calls over the weekend to garner support from other physicians (including then-OSMA President William Marshall, MD), but they quickly complied by sending a flood of supporting letters to city hall. Patients, too, were contacted to add their voice.

Still, Hamilton's city council wasn't yet convinced. Wouldn't the ordinance be self-serving?, they asked. Dr. Barich assured them that, if anything, the ordinance would take money *from* the physician's pocket — not add to it.

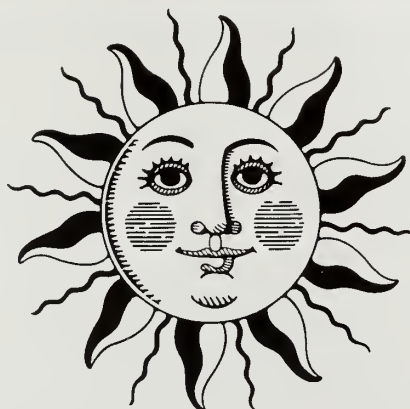
Hamilton city council adopted the new tanning parlor regulations on October 11, 1989, with an effective date of November 10, 1989.

From ordinance to Statehouse

"My goal was to help Hamilton develop the first tanning parlor ordinance, and then go to the sidelines," he says. But Dr. Barich is not one to remain on the bench long.

Continued on page 244

Legislation



Suggestions for Developing a Tanning Parlor Ordinance

If you are interested in getting a tanning parlor ordinance in your community, Dr. Barich offers the following suggestions:

1. Form a committee of dedicated, concerned volunteers. Especially any physicians in your community who have been concerned about the hazards of ultraviolet radiation.

2. Familiarize yourself with the Ohio State Medical Association resolution passed in May 1988 (Amended Resolution No. 68-88), regarding the hazards of ultraviolet radiation, and the resolution passed by the Ohio Dermatological Association on Nov. 11, 1989, encouraging communities to develop their own tanning parlor ordinance.

3. Pass a resolution pertaining to tanning parlors at your county medical society. Have a number of physicians prepared to speak on behalf of the resolution prior to the vote.

4. Purchase from the Skin Cancer Foundation the audiovisual slide show entitled "Skin Cancer Preventable and Curable." Obtain numerous brochures and posters pertaining

to skin cancer from the Skin Cancer Foundation, American Cancer Society and Academy of Dermatology and prepare packets to distribute to individuals in and out of government.

5. Develop a mailing list with the names and addresses of those in the government such as the health commissioner, city manager, mayor, law director and various council people who are responsible for passing ordinances.

6. Enlist the support of the health commissioner. Indicate to the health commissioner that you would like to work with him or her to develop a local tanning parlor ordinance that would result in an informed public consumer and a responsible tanning parlor operator.

7. Once you've won over the health commissioner go through the same educational process for the city manager, mayor, vice-mayor, law director and various council people. Preferably, educate one or two of the government officials at a time. They will appreciate this personal attention and education. As a

result you will have developed a stronger bond with them that will help with other health and political endeavors in the future.

8. While your community develops an ordinance consider displaying appropriate educational material on bulletin boards in doctors' offices, hospitals, schools, YMCA, YWCA, county fairs, industry, etc.

9. Enlist the support of your hospital administrators and cancer organization. Request that they join you in a combined effort by writing letters of support for the ordinance and sending them to various government officials.

10. Enlist physicians to attend the various council sessions and to speak on behalf of the ordinance.

11. Gain the support of your local newspaper, radio and television stations. Supply reporters with various literature to make their articles informative.

12. After successful passage of your ordinance remember to thank all those involved in a letter to the editor of your local newspaper. OSMA

Legislation

In addition to helping other communities make similar changes in their tanning parlor regulations, he has now taken the issue to the Statehouse, where, this past March, he, Mark Bechtel, MD, chair of the ODA's Legislative Committee, and Arnold L. Schroeter, MDH, ODA President, presented testimony at the first hearing of Senate Bill 38, sponsored by Sen. Charles Horn of Kettering. The bill attempts to do what Senate Bill 369 failed to do when it died in last year's legislative calendar. It proposes to amend a section of the Revised Code to require the State Board of Cosmetology to adopt rules requiring periodic testing of sun lamps used in tanning facilities. It also creates the Tanning Facilities Fund for deposit of tanning facility permit and permit renewal fees and would require training of tanning facility inspectors.

According to Dr. Bechtel, this bill puts Ohio on the cutting edge. If passed, it would be the first state law to change tanning parlor regulations in this fashion.

"Conceptually, the legislators understand the problem and see the merit of Dr. Barich's proposed solution," says Cynthia Snyder, JD, associate director of OSMA's Department of Legislation. "However, additional regulation by state agencies would entail additional costs to be borne by either the tanning parlor or the state, and at a time of dramatic cuts in state spending, new expenditures are going to be closely scrutinized."

If anyone can convince the state this regulation would be money well-spent, however, it would be Dr. Barich. "The orchestrated efforts he has made so far have been astonishing," Snyder says. "He shows a highly developed awareness of the legislative process."

Continued on page 260

Highlights of Hamilton's Ordinance

Listed below are some highlights from Hamilton's Tanning Parlor Ordinance which passed in October 1989:

- No tanning facility permit holder or tanning facility operator shall knowingly permit a consumer to use any tanning equipment that contains an ultraviolet light source the present output of which is less than 70% of its original output or that has not been changed at least as frequently as recommended by its manufacturer.
- Tanning parlor equipment must have an operational means of manually terminating the tanning equipment's operation without removal of its plug or coming into contact with its ultraviolet lamp.
- Equipment must also have a transparent cover to prevent contact between the user's body and the source of irradiation.
- Tanning beds or booths must be equipped with proper eye protection that absorbs all ultraviolet A, ultraviolet B and visible light up to 500 nanometers.
- A qualified operator who is at least 18 years of age and adequately trained in the operation of the facility must be present at all times. This operator must be able to inform and assist the consumer in the proper use of the tanning equipment.
- No operator should allow a consumer to use a tanning facility's equipment until the operator has determined the appropriate time period for the consumer's current exposure.
- The floor in the area where the tanning equipment is located must be dry.
- The tanning equipment's surface and control apparatus must be cleaned after each use with a cleaning agent capable of effectively killing viral, bacterial and fungal contaminants, and the consumer must be provided with a clean sanitary towel.
- Every tanning facility permit holder must create and maintain a permanent record for each consumer showing the dates of exposure and length of exposure.
- A statement must be submitted to the tanning parlor operator indicating any medication or drugs he or she is currently taking and an acknowledgment that the consumer has reviewed the photosensitizing agent list.
- The consumer must be advised of the maximum permissible ultraviolet exposure for the present session.
- A list of photosensitizing agents must be prominently displayed.
- A warning must be displayed on the informational form explaining the dangers associated with exposure to ultraviolet light.
- No person under 18 years of age is to use a tanning facility until the operator has been provided with written consent from the minor's parents.
- Appropriate personnel of the Hamilton Health Department can make periodic inspections of all tanning facilities within the city of Hamilton to determine their compliance with the ordinance. **OSMA**

AIDS and Your Office Staff

DETERMINING JUST WHO IS AT RISK

A nurse who works in your practice walks into your office and informs you that he or she has AIDS. As the nurse's employer, what do you do? What are your legal responsibilities to that nurse . . . to co-workers . . . to patients?

Admittedly, those are questions that not many Ohio physicians have had to answer. Despite the fact that the state ranks 13th in prevalence of the disease, with over 2,000 full-

blown cases and 50,000 Ohioans estimated to be carriers, the fact remains that health-care workers are not necessarily at high risk for HIV infection. Lois Hall, an epidemiologist with the AIDS unit at the Ohio Department of Health, says that the ODH does not keep AIDS figures by occupation, so she has no idea how many Ohio health-care workers have developed the HIV infection, but she is

guessing it's not many.

"As far as we're concerned, sex and drugs are still the high-risk factors. We don't consider those in the health-care profession to be at any greater risk than those in other professions," she says.

Just because the risks are no greater, however, doesn't mean that they are not there — or that physicians can afford to ignore the matter entirely. In fact, the health of their practices may well depend on the health of their staff.

"A physician is responsible for the welfare of a patient, even if he or she has delegated some areas of care to another person," says Katrina English, JD, OSMA staff counsel. That means if a case of HIV virus is transmitted to a patient by one of the physician's employees, he or she may be held liable.

That factor alone may motivate some physicians to assess the risk of AIDS in their offices. But how can they legally do this?

One way, of course, is to institute a mandatory AIDS test for your employees.

"Employers may require blood and urine tests of their employees to test for such things as drugs and AIDS," says English.

However, she cautions physicians to obtain informed consent from their employees, either orally or in writing, before administering these tests. In Ohio, informed consent for AIDS testing means that the

Continued on page 247



Legal

Ohio Department of Health Informed Consent to HIV Antibody Test (Testing for the AIDS Virus)

Editor's Note: *This form is not mandatory for HIV testing. However, if used, this form satisfies statutory requirements for informed consent for HIV testing.*

Before an HIV test can be given in Ohio, consent is needed. If you have questions, please ask your doctor or counselor.

1. What is the HIV Antibody Test?

The HIV antibody test is a blood test. The test shows if you have antibodies to the virus that causes AIDS. A sample of your blood will be taken from your arm with a needle. If the first test shows that you have antibodies, a series of tests including a different test will then be done on the same blood sample to make sure the first test was right. A positive test result means that you have been exposed to the virus and are infected. It does not mean that you have AIDS or that you will necessarily become sick with AIDS in the future. A negative test means that you are probably not infected with the virus. It takes the body time to produce HIV antibodies. If you have been exposed to HIV recently, you need to be retested in several months to make sure you are not infected. Your doctor or counselor will explain this to you.

2. Voluntary Testing

Taking an HIV antibody test is voluntary. You do not have to take the test. Consent may be withdrawn at any time before you leave the premises where your blood is drawn for the test.

If you are under age 18, you

may consent to be given an HIV test.

If you do not wish anyone to know your test results or even that you have been tested, you can go to an anonymous test site. This is a place where you can receive counseling and the HIV test without giving your name and or address. You can find the nearest anonymous test site by calling the AIDS Hotline 1-800-332-AIDS.

3. Behaviors That Pose Risk

Most AIDS infections are spread through certain sexual activities or sharing of intravenous needles. Either anal or vaginal intercourse with an infected individual can transmit the virus. Oral intercourse with an infected individual may also spread the infection. An infected woman can pass the virus on to her unborn child.

4. What is the Value of an HIV Antibody Test?

If you test negative.

- You can learn how to continue to avoid getting infected; ask your counselor for advice. Getting education through counseling is the key to preventing the spread of AIDS.
- If you test positive:
 - You can learn how to avoid giving the virus to others.
 - With this information your doctor can take better care of you.
 - If you are a woman or a man thinking about having a baby, you can learn the risk to your baby.

5. Confidentiality of Test Results

If you take the HIV antibody

test, your test results are confidential. Under Ohio law, confidential HIV-related information can only be given to the people you allow to have it by signing a release form, or those persons listed below.

6. Risks Involved With Disclosure and Sources of Help

If you test positive, you should be careful about telling others what your test showed. Some HIV positive people have been discriminated against by employers, landlords and others. If you experience discrimination because of release of HIV related information you may contact the Ohio AIDS Hotline 1-800-332-AIDS.

7. For More Information

For a list of resources for further counseling or support, ask your doctors or counselor. If you have further questions about HIV antibody testing, you may contact the Ohio AIDS Hotline 1-800-332-AIDS.

Informed Consent to HIV Antibody Test

I have reviewed the information in the informed Consent to HIV Antibody Test. My questions about the HIV test have been answered. I agree to take the HIV antibody test.

DATE

Signature of person who will be tested (or guardian if appropriate)

Legal

AIDS



employee has been told what the test is; that the test is voluntary (although the employer *is* within his or her rights to make AIDS testing a condition of holding the job); and about behaviors known to pose risks of transmission. The best way to appropriately obtain informed consent to test for AIDS is to utilize the consent form developed by the ODH (see sidebar).

"The fact that an employee shows up at the lab for a blood test after you've explained the test could be construed as consent," she says. However, if that employee was told the test is for hepatitis, and you decided to have the lab

check for signs of HIV infection as well — then notify the employee that you have ordered the AIDS test, or risk landing in legal hot water.

"There are incidents where an AIDS test can be done without prior informed consent (see sidebar for those incidents), but in Ohio,

you cannot legally test for the HIV infection unless the person who is being tested has been notified of the nature of the test and has provided the level of informed consent applicable to AIDS testing," says English.

Any physician who randomly and indiscriminately sends blood to a lab for an HIV test faces the possibility of a lawsuit.

A lawsuit may also be filed if the test results are disclosed to anyone other than the employee.

"AIDS is a self-reporting condition," English points out. That means it is up to the nurse with AIDS to report his or her condition to the Ohio Board of

Exceptions to Informed Consent

Informed consent, explanation and counseling requirements of section 3701.242 of the law do not apply to the performance of an HIV test in any of the following circumstances:

1. When the test is performed by a physician or a registered nurse in a medical emergency and the test results are medically necessary to avoid or minimize an immediate danger to the health or safety of the individual to be tested or another individual, except that counseling shall be given to the individual as soon as possible after the emergency is over;
2. When the test is performed by a person who procures, processes, distributes, or uses a human body part from a deceased person donated as an organ donation, if the test is medically necessary to ensure

that the body part is acceptable for its intended purpose;

3. When the test is performed for the purpose of research if the researcher does not know and cannot determine the identity of the individual tested;
4. When the test is performed on a person incarcerated in a penal institution under the Department of Rehabilitation and Correction if the head of the institution has determined, based on good cause, that a test is necessary;
5. When the test is performed by or on the order of a physician who, in the exercise of his or her professional judgment, determines the test to be necessary for providing diagnosis and treatment to the individual to be tested, if the individual or his or her parent or guardian has given consent

to the physician for medical treatment;

6. When the test is performed on an individual after the infection control committee of a health-care facility or other body of a health-care facility performing a similar function determines that a health-care provider, emergency medical services worker or peace officer, while rendering health or emergency care to an individual, has sustained a significant exposure to the body fluids of that individual, and the individual has refused to give consent for testing;
7. Consent of the individual to be tested is not required, and the individual or guardian may not elect to have an anonymous test, when the test is ordered by a court in connection with a criminal investigation. **OSMA**

Legal

Nursing. It is *not* the responsibility of the physician-employer.

However, if a physician has discovered, through an AIDS test, that an employee is infected, the physician does have the responsibility of reporting that condition to both the employee and the Ohio Department of Health. The physician also has the responsibility of performing follow-up counseling with the employee or referring him or her to the appropriate agencies for counseling.

Should you allow that employee to continue working in your office? Again, this is a decision that the physician is going to have to make for him or herself. You have the option, of course, of restricting that employee's duties to those that are removed from patient care. However, you may be on shaky legal ground if you decide to terminate the employee.

In general, people infected with the HIV virus have the same protection against discrimination as other disabled people. However, English points out that in discrimination cases so far, employees with AIDS who work in health-care settings and in the food-service field have sometimes been successfully terminated by their employers. That may be because their infectious condition prohibits them from doing many of the jobs they were hired to do, and if they're unable to do the job, then there is no law that states they must be afforded the job.

If the employee is terminated, the physician is *not* at liberty to pass along information about the employee's condition to his or her next employer.

"That information is absolutely confidential under Ohio law," says English.

Of course, the best offense for

any physician-employer is a good defense, and English encourages all physicians to initiate in their practices the universal precautions against infectious diseases, including AIDS, if they haven't already done so. These are available through the Centers for Disease Control.

Certainly, it seems ironic that, at a time when mandatory AIDS testing for all health-care workers (including physicians) has come under hot debate, physicians are weighing these very matters within the scope of their own practices.

Yet, as physicians who are responsible for the safety and welfare of their patients, it may be important for them to do so. As the AMA has stated in its position on HIV-infected physicians, "In cases of uncertainty about the risks to patient health, the medical profession, as a matter of medical ethics, should err on the side of protecting patients. The health of patients must always be the paramount concern of physicians." **OSMA**



Who Can Receive HIV-Related Information

Under Ohio State Public Health Law, HIV-related information is confidential and may only be given:

A. To you; B. To your legal guardian; C. To your spouse or sexual partner; D. To a person authorized by you or your guardian in written release; E. To your physician; F. To the Department of Health or a health commissioner; G. To agencies involved in screening your donated body parts; H. To health-care facility groups conducting program reviews; I. To law enforcement authorities with a search warrant or a subpoena; J. To health-care providers who are treating or caring for you.

You have the right to ask the person who tested you if HIV-related information has been released to anyone listed above.

OSMA

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Patients At Risk?

DO THIRD PARTIES
THREATEN YOUR
PATIENTS' HEALTH?



Ohio's medical community generally perceives third-party payors as interlopers in the field of medicine. Their decision and mandates, physicians say, frequently

interfere with the delivery of quality medical care. Yet just how *health-threatening* is this third-party interference to patients?

OSMA's House of Delegates debated this question at its 1990 Annual Meeting. What finally emerged from the open, and sometimes heated, discussions was Amended Resolution 14-90, which called for a survey of Ohio physicians to "determine the prevalence of health-threatening actions by third-party payors throughout the state."

At the beginning of this year, then, the OSMA's monthly newsletter, *Third-Party Update* carried this survey. Member-physicians were asked if they had experienced any action by HMOs, PPOs, IPAs or other health insurance carriers in the last two years that resulted in health-threatening actions to the patient.

The 1990 House wanted hard data on this issue, and that is precisely what has come into OSMA offices over the past few months — from all four corners of the state.

The results of the survey are summarized below.

Pre-certification denials and delays

Respondents had an opportunity to point to one or more problems that physicians regularly experience when dealing with third-party payors.

According to the survey responses, no one problem seemed to rise well above the others. All totals were close. However, there is some indication that the majority of physicians who *are* seeing health-threatening action to patients as a result of third parties attribute the danger to pre-certification of admission or service, which resulted, in most cases, to denial or delay of care.

Members pointed to numerous experiences in their own practices

Reimbursement

to illustrate the problem. One of the most telling came from a respondent who recalled the following incident: "(The insurer) was called on the morning of November 16 for pre-certification of hospital admission for acute labyrinthitis, nausea and dizziness, etiology unknown. I started treating the patient on November 14th (but by the 16th), his condition was much worse. He is a very large man, and it was all that his wife and my office staff could do to get him to ambulate. We called the insurance company several times in the course of the day, only to get a denial and a promise that the medical director would call to speak with me directly on the need for admission. He did — three days later."

Length of stay denials

Close behind problems with pre-certification denials and delays are problems with length-of-stay denials.

Physicians are frustrated by third-party payors who are anxious to send patients home before they're ready.

One physician, in fact, included with his response a letter he had written to an insurance company, asking its legal representative to discuss "responsibility in circumstances such as this, when a patient is discharged before the attending physician feels the patient is ready to be discharged." No responding legal letter was attached.

Medically unnecessary services denial

This proved to be the third most prevalent problem Ohio physicians are experiencing with third-party

payors, according to the OSMA survey.

One physician told of an insurance company that refused to pay for a surgical assistant on the grounds that the assistant was "medically unnecessary." A similar story came in about a family practitioner who was denied payment for diagnosing and treating a pre-existing condition that had been aggravated by a surgery (which was covered).

Another respondent noted that carpal tunnel surgery was done on one patient without pay because coverage would not go through until the condition reached severe proportions.

Other problems

Three remaining problems continue to frustrate physicians. They were ranked by respondents in the following order (from most problematic to not-quite-as-bothersome):

- Denial of use of non-participating HMO/IPA/PPO facility or physicians.
- Concurrent care review denial and
- Quality of care denial.

Each, of course, brought more stories.

No matter what the problems seem to be, however, the survey clearly reveals physicians' growing impatience with third-party payors. Respondents wrote of "losing one's cool" and having to resort to monosyllabic descriptions to convince a claims reviewer to continue coverage. Some indicate that the majority of problems come after discharge, but still others are unable to get their patients through the hospital doors. "One insurer told me a

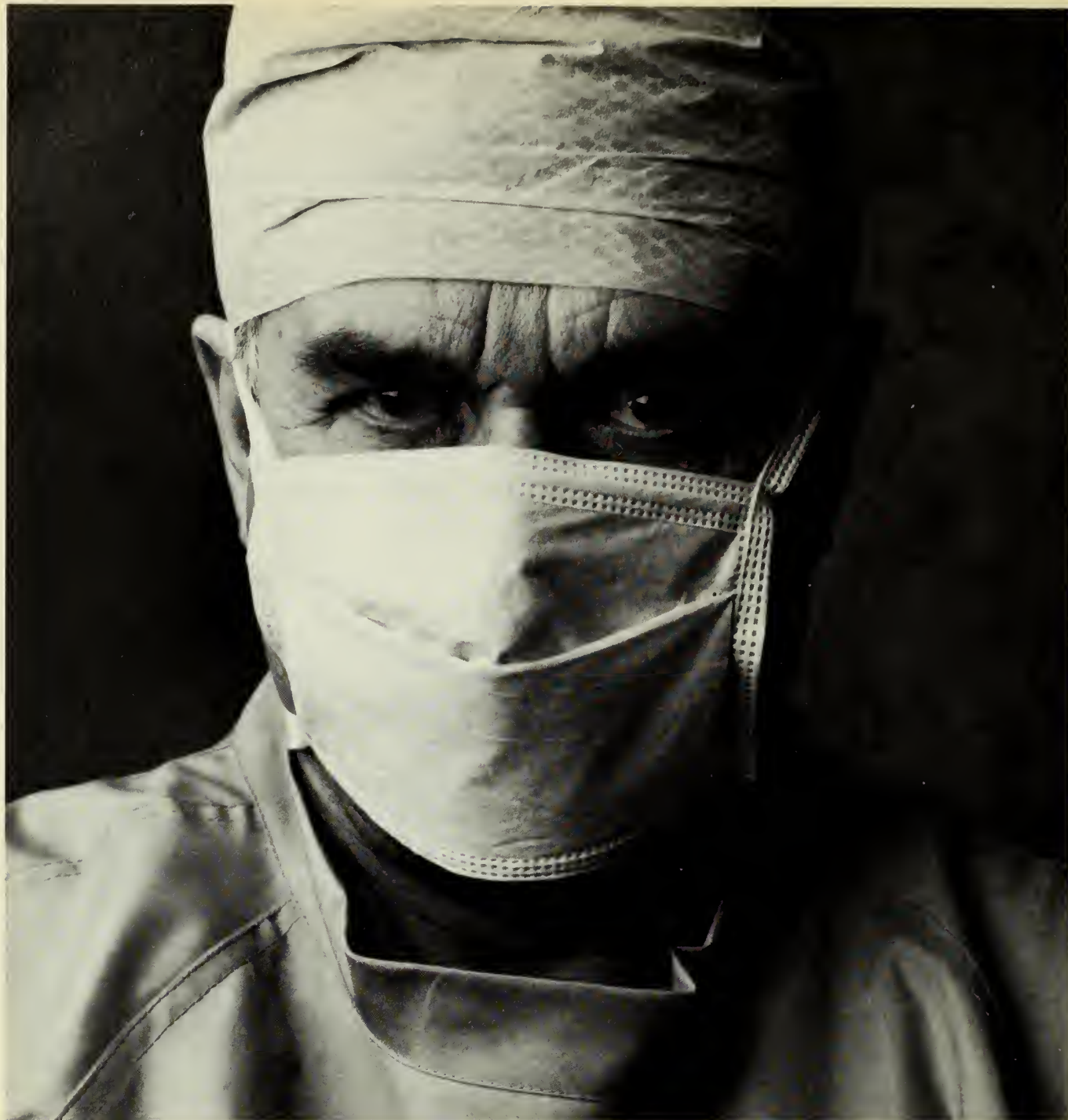
suicidal patient could be treated on an outpatient basis," wrote a physician.

"They are all health-threatening," another respondent notes. Then, taking a more radical tone continued: "We are starting to think of third parties first and the patient's welfare second. We need a union!"

If you are experiencing problems with third-party payors, maybe the OSMA can help. The Ombudsman department often intervenes in third-party disputes on the physician's behalf.

In addition, the OSMA Communications Department has available patient information brochures that describe the strengths and weaknesses of various insurers.

Third-party problems are likely to remain a continual sore point in the years ahead. The OSMA, however, may offer you your best line of defense. Don't hesitate to call. **OSMA**



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Gustave Courbet (1819-1877) was one of the most important artists of the last



century. He was an inspiration to the Impressionists in his vigorous stand against the art world establishment, and by his interest in subjects taken from everyday life.

When he came to Paris to paint in the 1840s, the French Academy and Salon held artistic power. Academic painting with gods, goddesses, knights and damsels, which appear artificial to us today, was standard fare at that time. Courbet's realistic subject matter, everyday people doing everyday things, was considered ordinary, even vulgar and subversive of artistic standards to academicians.

Actually, Courbet was subversive, and a socialist to boot. He would have been best off had

he avoided politics altogether. He was offered the great distinction of being a Chevalier of the Legion of Honor in 1870 during the reign of Napoleon III. After the fall of the Second Empire, Courbet joined the commune and was elected president of the Commission of Artists, with the task of safeguarding art. He was implicated in the destruction of the imposing Vendome Column in Paris, was sentenced to prison, and was fined a huge sum of money.

Courbet loved to drink wine, particularly that wine produced in the mountainous area of eastern France and neighboring Switzerland, which was well known for producing widows. In the 1850s he developed gastrointestinal symptoms, including jaundice and hemorrhoids. His discoloration earned him the sobriquet "the Prince of Orange."¹ In the 1860s he entered a beer-drinking contest in Munich. On day one there were 60 entrants, on day two 15 remained, on day three 10, and on day four Courbet defeated the remaining two drinkers.² In the 1870s the famous French surgeon August Nelaton examined him, later found an intestinal stricture and hemorrhoids, and operated. Later, Courbet developed an enlarged cirrhotic liver and pains in the area of the lower ribs.

During his last years he became thin except for severe enlargement of the abdomen (60 inches) and

By James G. Ravin, MD

Art and Culture

severe swelling of the legs. Many times the abdominal swelling was treated by tapping the abdomen and draining off 10 to 20 liters of fluid. Finally poor Courbet succumbed to a miserable demise from this liver ailment. He left behind hundreds of fine canvasses and achieved strong support for his realistic mode of painting.

The Trellis, in the collection of the Toledo Museum of Art, is an important work by Courbet. The carefully modeled girl and brilliantly colored flowers create a pleasant image. The exhibition catalogue for the large retrospective given the artist during the centennial year of his death described this painting: Its "purpose is to glorify youth and love by representing a young girl with flowers of spring, summer

and autumn, symbolizing the stages of her amorous life. Thus in *The Trellis* we see primulas, hollyhocks and begonias — the blossoming of which corresponds to the whole span of human life and happiness."³ OSMA

References

1. Lindsay, J: *Gustave Courbet, His Life and Art*. NY: Harper and Row, 1973, p. 123.
2. Mack, G: *Gustave Courbet*. NY: Knopf, 1951, p. 232.
3. *Gustave Courbet*. (catalogue) London: Arts Council of Great Britain, 1978, p. 144.

James G. Ravin, MD, is a member of the OHIO Medicine Advisory Committee, and chair of OSMA's Committee on Art and Culture.

Our Cover:

Courbet, "The Trellis"
Oil on canvas, 1862
Toledo Museum of Art
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competent manner.

Planning, according to the consultant, is the application of thought, analysis and imagination. The OSMA Council accepted that premise and spent two days of intensive concentration addressing the problems, proposing solutions and projecting a plan of action to ensure that Ohio physicians receive the best possible guidance, protection and support.

It is time that all Ohio physicians join together to give the medical community the strength to meet and combat forces that would endanger the rights of physicians to provide patients that quality of care that physicians are capable of rendering.

No other group can provide the total support and knowledge that the OSMA can for physicians. Value your membership and become a recruiter for others to join. There is strength in numbers and today we need those numbers to be effective. **OSMA**

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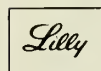
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A complete, accurate and objective medical chart is an excellent foundation for defense against allegations of negligence, improper treatment or omissions in care. An incomplete record enables a plaintiff's attorney to challenge the physician's testimony, and may encourage the attorney to prosecute a medically defensible case.

The medical record is frequently the key document in a medical malpractice lawsuit. Your office record and the hospital chart are the documents that reflect patient care and communication. Be conscientious and thoughtful in their

preparation. Maintain complete and adequate medical records, including detailed and accurate entries that describe fully the patient's medical history, physical findings, differential diagnosis, treatment plan and any other matter that you believe to be pertinent to the patient's medical care.

Make all entries in a neat and legible fashion, always using ink. If you can't read your entries — chances are no one can read them either! This could result in a misinterpretation and injury to a patient or may damage your credibility with a jury in a lawsuit.

Record chart entries in a timely fashion recording accurate, factual information in an objective — not subjective—fashion. Use accepted hospital and medical abbreviations and terminology.

Never alter the medical record! Do not attempt to erase, overwrite, obliterate or white out entries. In case of an error draw a *single* line through the erroneous statement, initial and date it. Finally, sign each entry and postscript with your first and last name and professional designation, always include the date.

The following information will help you assess your office medical records.



Loss Awareness

Charting Habits

- Are chart notes readable?
- Are all chart entries signed and dated?
- Are all no-shows/cancellations indicated in the chart?
- Are corrections and additions to the chart entered chronologically, dated and signed?
- In your absence, could a colleague, using appropriate information from the medical chart, provide your patients with immediate and appropriate care?

Office Charting Procedures

- Are missed/cancelled appointments (reason included, if known) noted on the chart?
- Are all telephone conversations (physician as well as staff) regarding patient care noted on the chart?
- Are all drug allergies noted prominently on the chart? Are all lab/X-ray reports seen and initialed by the physician before placement in the chart?
- Are signed, dated authorizations obtained and placed in the chart before copies of the chart are released?
- Is it noted on the chart where the copy is being sent?
- Is physician authorization required before records can be released?
- Is there a standard procedure for termination of care that is followed in your office?

Patient History

- Do you chart the reason for the patient's visit, including all complaints?
- Do you chart the patient's history, including past medical treatments, current medications, drug allergies, family history, etc.?
- Do you document your investigation of question marks

and blank spaces left on the questionnaire?

- Do you chart all your physical findings?
- Do you chart negative findings?
- Do you diagram size and location of suspicious lumps and lesions?
- If yes, do your patients sign or initial these diagrams?

Treatment and Follow-up

- Do you outline a treatment plan that is supported by the findings in the workup and diagnosis?
- Do you chart obtaining the patient's informed consent?
- When appropriate, do you chart the patient's informed refusal?
- Do you chart patient compliance or non-compliance with recommendations?
- Do you chart all instructions to the patient, including follow-up requirements?
- Do you chart who is responsible

for follow-up, patient or physician?

- Do you chart recommendations for referral to outside care or follow-up?

Select a few office records that contain entries made in the last six months. Review them carefully based on the factors listed above. It is increasingly important to see where your office medical record-keeping strengths and weaknesses lie. In today's legal climate, a deficiency involving any of the items outlined above could expose you to a professional liability lawsuit. **OSMA**

The Loss Awareness Bulletin is provided each month through the OSMA Task Force on Professional Liability and its subcommittee on Loss Awareness with the assistance of the Physicians Insurance Company of Ohio.

NEXT MONTH'S ISSUE



- A dialogue with new OSMA President Joseph Sudimack, Jr., MD.
- Ohio State Medical Board tackles physician fee review.
- What OSMA is doing to educate the public about UHIO.
- Corporate punishment and the optometrists are back.

Lot Syndrome (hypercalcinosis)

OF CALCIUM AND SALT?

The term Lot Syndrome has been applied to patients with a considerable amount of calcium deposited in tissues as a result of increased concentration of calcium in the blood.¹ The most frequent cause of such metastatic calcification is release of a large amount of calcium by excessive bone resorption.² This occurs in hyperparathyroidism and in vitamin D intoxication.

Lot was the nephew of the biblical Abraham. He was warned to leave the sinful city of Sodom before it was destroyed by God, and not to look behind. "But his wife looked back from behind him, and she became a pillar of

salt."³ Although calcium is a metal, it is combined as a lime salt in the body. The biblical reference to a pillar of salt may, however, have been to sodium chloride. Southwest of the Dead Sea in Israel there are fantastically shaped masses of rock covered with salt.⁴

Unlike metastatic calcification, Lot's wife was completely transformed into salt. More compatible is the lithopedion, which refers to complete calcification of a fetus retained in the mother's body after it dies. "Lot's Wife" has been suggested as a more appropriate eponym, as it was she who looked back. The phrase Lot's Wife has already been usurped, however, for yet another eponym (see Lot's Wife Syndrome). **OSMA**

References

1. Vaisrub, p. 22.
2. Berkow, p. 938-939.
3. OT: Genesis 19:26.
4. Krause, L.: Salt: *Maryland State Med. J.*, 1:277-281, 1952.
5. Doré, G.: *Doré's Bible Illustrations*: New York, Dove, 1974, p. 13.



Obituaries

EDGAR M. CORRILL, MD,
Cincinnati; University of
Cincinnati College of Medicine,
1941; age 73; died June 14, 1990;
member OSMA and AMA.

GILBERT DICKERHOOF, MD,
Cleveland; Ohio State University
College of Medicine, 1943; age 75;
died February 16, 1991; member
OSMA and AMA.

JOHN E. GRAUEL, SR., MD,
Vermilion; Case Western Reserve
University School of Medicine,
1946; age 70; died February 17,
1991; member OSMA and AMA.

WILLIAM H. HAVENER, MD,
Columbus; Case Western Reserve
University School of Medicine,
1948; age 66; died March 7, 1991;
member OSMA and AMA.

HOMER I. KECK, MD,
Massillon; Ohio State University
College of Medicine, 1939; age 79;
died February 23, 1991; member
OSMA.

FRANCIS G. KRAVEC, MD,
Youngstown; Loyola University
Stritch School of Medicine,
Maywood, IL, 1939; age 80; died
June 16, 1990; member OSMA and
AMA.

MERRITT K. MARSHALL, MD,
Marion; Ohio State University
College of Medicine, 1937; age 80;
died February 17, 1991; member
OSMA and AMA.

CECIL MCINTIRE, MD, South
Charleston; University of
Cincinnati College of Medicine,
1936; age 80; died December 21,
1990; member OSMA and AMA.

JOHN NOLL, MD, Worthington;
Cornell University Medical
College, New York, NY, 1929; age
87; died February 21, 1991;
member OSMA and AMA.

LESLIE A. PATTEN, MD,
Columbus; Ohio State University
College of Medicine, 1943; age 72;
died March 9, 1991; member
OSMA and AMA.

RALPH A. POLUMBO, MD,
Columbus; Case Western Reserve
University School of Medicine,
1965; age 51; died February 3,
1991; member OSMA.

LOUISE W. RAUH, MD,
Cincinnati; University of
Cincinnati College of Medicine,
1929; age 88; died February 27,
1991; member OSMA and AMA.

RUDOLPH A. STYBLO, MD,
Elyria; St. Louis University School
of Medicine, St. Louis, MO, 1933;

age 83; died February 16, 1991;
member OSMA and AMA.

LAYMOND SWINEHART, MD,
Cortland; University of Cincinnati
College of Medicine, 1950; age 72;
died February 14, 1991; member
OSMA and AMA.

WILLIAM C. WEIR, MD,
Cleveland; Harvard Medical
School, Boston, MA, 1935; age 81;
died February 11, 1991; member
OSMA and AMA.

EDWARD M. ZUCKER, MD,
Massillon; Ohio State University
College of Medicine, 1938; age 77;
died January 25, 1991; member
OSMA and AMA.

Dr. Lou Barich . . . continued

Kent Studebaker, Director of
OSMA's Department of Medical
Society and Member Relations,
agrees, and applauds Dr. Barich's
efforts.

"There are few proactive
legislative processes undertaken by
physicians in general and
specialists in particular. Dr. Barich
is to be commended for his
efforts," he says. Then, he adds:
"I think it's important to point
out that this is a good example of
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complaints that physicians only
bring up economic issues, but,
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usually not attributed to one
factor," Dr. Barich explains. "I
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"There are only so many
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that can be spent on health
care," he continues. "It behooves
all of us to prevent as many
diseases as possible and to
become a healthier nation."

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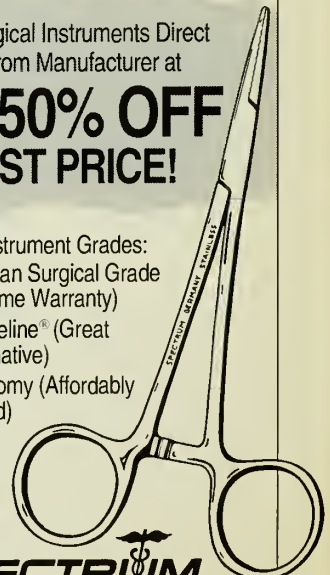
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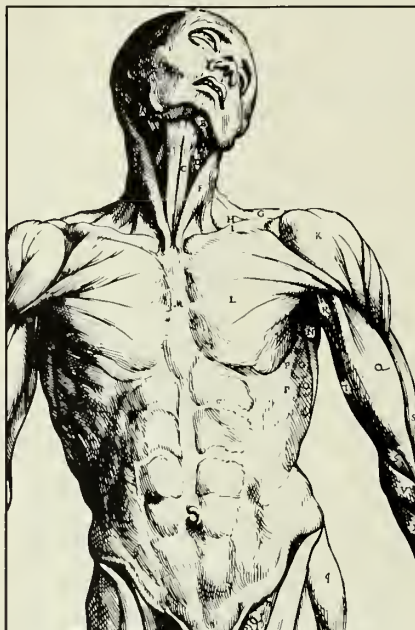
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Ophthalmology

"Ocular, Adnexal & Orbital Infections and Inflammatory Diseases," June 14-15, Bunts Auditorium, Cleveland Clinic, 9500 Euclid Ave., Cleveland, Ohio. Sponsored by the Cleveland Clinic Educational Foundation. For information: (216) 444-5696 or (800) 762-8173.

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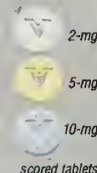
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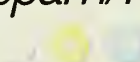
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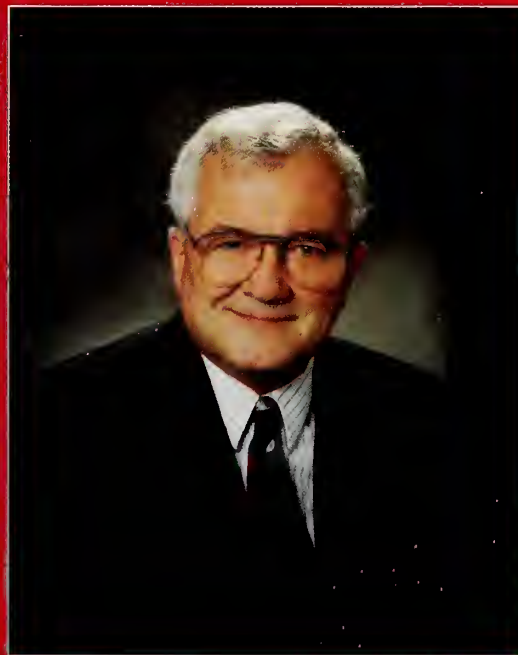
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House of Delegates action on resolutions

(Please see other side for coding.)

Here are the results of the resolutions considered by the House of Delegates at the 1991 OSMA annual meeting held May 16-19 in Columbus.

Resolution number and name	Referred to Council	Amended, Adopted	Rejected	Resolution number and name	Referred to Council	Amended, Adopted	Rejected
Reimbursement				31. Unannounced PRO Enforcement of Regulation		✓a	
1. Third Party Reimbursement for Telephone Time		✓a		32. PRO Physician Adviser Confidentiality		✓a	
*3. Insurance Company Review System		✓a		HIV/AIDS			
*4. Increased Third-Party Payor Accountability				*45. Physician-Initiated AIDS Testing			
5. Reimbursement Rates for Medical Services to Medicaid Patients		✓a		46. AIDS Testing with Patient's Consent			
6. Correct Rural Medicare Payment Inequality	✓			*47. More HIV Testing of Patients			
7. Medicare Discrimination Against Huron County	✓			*48. AIDS Resolution			
8. Mandatory Reimbursement for FDA-Approved Antineoplastic Chemotherapy Drugs Used in Non-FDA-Listed Indications		✓a		49. AIDS Resolution Regarding Individual Hospital HIV Policies			
10. Physician Billing Statements — Standardized Explanation of Benefits to Patients		✓a		50. Safety Net for Health Professionals Who Become HIV Seropositive on the Job	✓		
14. Timely Early Disclosure of All Limiting Charges		✓a		51. Support for and Development of Statewide Risk Pools for HIV-Positive Physicians			x
20. Private Sector Proposal for Part B Medicare			x	52. Expansion of Workers' Compensation Benefits for HIV-Positive Physicians	✓		
25. House Bill 65			x	OSMA			
26. Concurrent Care			x	2. Reorganize OSMA as a Labor Union			x
Uninsured health care				*33. Emeritus OSMA Delegates to the AMA			
16. Medical Economics	✓			44. Women in Medicine		✓	
22. Health Access America Credibility		✓a		*68. Medical Student Page of <i>OHIO Medicine</i>			
Public Health				*69. "The Delegate's Report"			
18. Prevention of the Overmedication of Elderly Patients	✓			*71. Proposed Revision of OSMA Constitution and Bylaws			
53. Prevention of Sexually Transmitted Human Papillomavirus (HPV) Infections		✓		*72. Specialty Society Representatives			
57. Cancer Registry		✓		Ohio State Medical Board			
59. WTI — Waste Incinerator		✓a		54. Ohio State Medical Board Categorization of Physician Penalties		✓	
60. Education of Students on the Hazards of Ultraviolet Radiation (Tanning Rays)		✓a		55. Ohio State Medical Board Investigations		✓✓	
61. Infectious Disease Precautions for Cadaver Transport		✓a		56. Ohio State Medical Board Proposed Licensure Legislation	✓		
*62. Strengthening Ohio's Helmet-Use Law for Motorcycle Riders		✓a		58. Medical Licensure		✓a	
*63. Mandatory Use of Protective Helmets				Liability			
64. Permanent Cosmetic Make-Up		✓✓		35. Support for Health Clinics		✓	
65. Substance Abuse As A Public Health Hazard		✓✓		39. Expert Witness Testimony		✓a	
67. Sample Medication Instruction Forms		✓a		Miscellaneous			
PPOs				9. Health Benefit Plans		✓	
*11. Support of the American Academy of Ophthalmology's Opposition to the Cataract Preferred Provider Demonstration Project		✓✓		15. Cost of Medical Care — Market Research Study			x
*12. HFCA Procedural PPOs				16. Medical Economics	✓		
13. Physician and Medical Staff Liability in Managed Care and Hospital PPO Contracts	✓			17. Co-Sponsorship of CME Programs			x
Peer Review				19. Quality of Life Issues Considered in Life-Prolonging Therapy		✓a	
23. Peer Review Organization Quality Assurance — Burden of Proof			x	*21. Membership Campaign		✓a	
24. Ohio State Medical Association Peer Review Process			x	34. Child Care in Hospitals		✓a	
27. PRO Quality Inquiry Letter	✓			36. Pre-Admission Evaluations by Limited Practitioners		✓a	
28. PRO Hospital Comparison Data			x	37. Limiting Terms of Office in the AMA		✓	
29. PRO — Abuse of Statutory and Regulatory Power		✓a		38. Substance Abuse Questions on Hospital Staff Application/Reapplication Forms	✓		
30. Revising the PRO			x	40. Hospital Medical Staff Physicians "Bill of Rights"		✓a	
				41. Inclusion of National Board of Medical Examiners Registration Fees Within Tuition Payments		✓a	
				42. Certificate of Medical Necessity			x
				43. Advertising Board Certification	✓		
				66. In Recognition of Thomas E. Fox, MD		✓	
				70. Osteopathy 100-Year Anniversary		✓	

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Coding for chart

a — amended

Reimbursement

*3 — Substitute Resolution 3-91 replaced resolutions 3 & 4

*4 — see above

Public Health

*62 — Substitute Resolution 62-91 replaced resolutions 62 & 63

*63 — see above

PPOs

*11 — Substitute Resolution 11-91 replaced resolutions 11 & 12

*12 — see above

HIV/AIDS

*45 — Substitute Resolution 45-91 replaced resolutions 45, 47 & 48

*47 — see above

*48 — see above

OSMA

*33 — Resolution 33-91 was withdrawn

*68 — Resolution 68-91 was withdrawn

*69 — Resolution 69-91 was withdrawn

*71 — Postponed for further consideration by the House of Delegates until OSMA Annual Meeting 1992

*72 — see above

Miscellaneous

*21 — Resolution 21-91 was withdrawn

Emergency Resolutions

The following emergency resolutions were considered at the OSMA Annual Meeting:

03-91 State Medical Board

Investigations —
amended/adopted

04-91 Coverage of Drugs by
Medicaid — adopted

05-91 OBRA 90 Medical
Reimbursement for
Prescription Drugs
amended/adopted

Hospital Medical Staff Resolutions

The following HMSS resolutions were considered at the OSMA Annual Meeting:

73-91 Physician Fee
Determination — adopted

74-91 Recognition of OSMA-
HMSS Founders —
amended/adopted

75-91 Economic Credentialing —
adopted

76-91 OSMA Legal Counseling
Services — referred to
council

Ohio Delegation to Take 12 Resolutions to AMA Annual Meeting

The following resolutions have been submitted to the AMA House of Delegates for consideration at its 1991 Annual Meeting this month:

- Timely Early Disclosure of All Limiting Charges Information (OSMA 14-91)
- Coverage of Drugs by Medicaid (OSMA E.R. 04-91)
- OBRA 90 Medicaid Reimbursement for Prescription Drugs (OSMA E.R. 05-91)
- Health Access American Credibility (OSMA 22-91)
- PRO — Abuse of Statutory and Regulatory Power (OSMA 29-91)
- Unannounced PRO Enforcement of Regulation (OSMA 31-91)
- PRO Physician Advisor Confidentiality (OSMA 32-91)
- Inclusion of National Board of Medical Examiners Registration Fees Within Tuition Payments (OSMA 41-91)
- Education of Students on the Hazards of Ultraviolet Radiation (Tanning Rays)
- Sample Medication Packaging (OSMA 67-91)
- Osteopathy 100 Year Anniversary (OSMA 70-91)
- Limiting Terms of Office in the AMA (OSMA 37-91)

One additional resolution, Pre-Admission Evaluations by Limited Practitioners (OSMA 36-91), is to be submitted to the AMA at its Interim Meeting in December.

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COVER STORY

Joseph Sudimack, Jr., MD, newly installed President of OSMA, recently took some time from his busy schedule to shed some light on the future of OSMA and what's in store for medicine. This busy and dedicated clinician has served in a variety of capacities at the OSMA during his 30-year tenure, ranging from Sixth District Delegate to Secretary-Treasurer, before assuming the position of president. Take a look at what Dr. Sudimack sees as the major issues facing medicine.

Photo by David's Studio

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Tort Reform — British Style

WHAT'S GOOD FOR THE UK COULD BE GOOD FOR THE US

This country is in serious need of tort reform for medical malpractice litigation. Major problems exist for all members of the medical community concerning professional liability. Many reasons for this occur, not the least of which is the extreme low risk to a plaintiff for filing a lawsuit, while there is a

high amount of cost for the defendant to prepare his or her case. An obvious inequity in the legal system exists.

To solve this country's problem of the uninsured, a two-tiered system of care for these

people has been proposed. We cannot continue to offer all things to all patients. Limitation of diagnostic and therapeutic efforts will undoubtedly be required. Some legal modifications will be necessary to adopt this strategy; otherwise doctors will be left with little defense. If our ability to do diagnostic and therapeutic procedures is limited, problems

will result.

A proposal that makes sense is to adopt the English doctrine concerning equitable recovery of legal costs. In England and in many parts of the British Commonwealth, the prevailing party in a lawsuit may recover legal fees from the losing party. The losing party may also be assessed court costs. The costs of legal fees are usually not recoverable in the United States. Each party in a case in this country is responsible for his own legal expenses. This has been justified as part of the privilege to access of the court system in our country, and can be termed the American doctrine.

Some may argue that following the English doctrine could prevent the poor from its rightful use of the legal system. However, in areas that have followed this doctrine, this does not appear to occur.

Some variations on the English doctrine do exist in this country concerning insurance, environmental and patent issues. Fee shifting also does apply in some states where the court can shift attorney fees from one party to another, which can protect the rights of the poor and allow them to bring suits to court.

This proposal has merit. It has been proven useful for many years in the United Kingdom. In our country this doctrine could benefit plaintiffs who have meritorious claims, while simultaneously decreasing lawsuits that have little merit. **OSMA**

By James
Ravin, MD



The opinions expressed in this column are those of the author and do not necessarily reflect the opinion or views of OHIO Medicine or the Ohio State Medical Association.

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Letters to the Editor

Of lawyers and litigation

To the Editor:

I found it of great interest that the President of The Ohio State Bar Association, Gerald L. Draper, JD was unwilling to consider the legal profession's responsibility for the current litigious medical environment. In only the second paragraph he states that "lawyers are involved in both sides of the cases and the judge is also a lawyer. To blame their participation as being the cause of the suit is no more logical than to blame surgeries on the surgeon." Here lies the fundamental problem between lawyers' thinking and physicians'. Mr. Draper fails to realize that physicians do accept responsibility for their actions and attempt to provide quality, responsible and compassionate care. Attorneys seem to feel that their actions need not be responsible to concerns of quality, costs and fairness, but only to the financial needs of their clients and firms. Obviously, this generates employment for all the lawyers that Mr. Draper mentions. Lawyers need to be concerned about the costs of liability to society and realize that their actions are often counterproductive. Having been involved in suits that were in fact deleterious to the plaintiffs' finances and emotional status as well as the defendants', I could find little solace in Mr. Draper's views.

It seems to me that the legal profession must take responsibility in giving honest counsel and avoiding frivolous legal actions. Courts of law need to become courts of socially responsive justice.

Mr. Draper also refers to bad feelings between physicians and

lawyers through the litigation process. I doubt that he really understands how offensive it is to have testimony twisted and distorted and purposely misleading, not in an effort to find out "the truth" but to "win the case." I recently had a very prominent attorney attempt to discredit me by implying that I had released medical information without proper consent. Interestingly, this was a complete fabrication on his part as he had the consent with his trial information. His interests were winning the case and not justice.

I feel that it is unfortunate that Mr. Draper is unwilling to be introspective in considering the legal profession's role in our litigious society. As long as lawyers like Mr. Draper control judicial and legislative process, I see little opportunity for positive change.

Sincerely,
Steven G. Roshon, MD,
FACP
Sandusky

To the Editor:

I am submitting this letter to the editor as a response to the guest editorial by Mr. Gerald Draper, which appeared in the April edition of *OHIO Medicine*.

Mr. Draper's article once again states an ancient attorney maxim: that lawyers are insulated from the righteousness of the position they have taken, because the client brought the suit. The attorney is only the mechanism to play out the client's wishes. This high and mighty ideal is not only inaccurate,

but is downright silly in today's malpractice and litigation environment.

We all know how the majority of attorneys conduct themselves in the pursuit of nonsense claims, not to mention those lawyers who directly attract clients through paid media advertising. Professionals, in my opinion, are in fact responsible for every position they take and every cause they champion. If an attorney takes on and promotes a position that is unfair and fraudulent, then he or she is a liar, plain and simple.

For too long, attorneys have insulated themselves from correct ethical and moral conduct by using the shield suggested by Mr. Draper. One either conducts oneself truthfully and ethically, or one is a fraud. All professions have their charlatans, but the general level of integrity that exists between physicians and lawyers just cannot be compared. The attorneys lose.

Sincerely,
Wayne Poll, MD
Columbus

OHIO Medicine

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Ohio Medi-Scene

Odd healing devices highlight collection

While strolling through the Lindan Historical Collection of Electro-Therapy and Unusual Healing Devices located in Cleveland, one might stumble upon a machine that claims it cures everything from "nerves" and paralysis to indigestion and gout, or an electric-shock device that miraculously zaps a person back to health.

These items are just a few of the unusual healing devices collected over the years by Olgierd Lindan, MD. The 77-year-old retired physician and former associate professor of medicine at Case Western Reserve University School of Medicine has spent the better part of his life pursuing this unusual hobby.

Dr. Lindan's collection is purported to be the world's largest, featuring everything from odd weight-loss treatments and rheumatism remedies to cures for baldness and impotence.

According to Dr. Lindan, "During the 19th and 20th centuries, electricity was the fashionable treatment for an assortment of ills."

A few examples of some of his medical experiments include:

- Vision Dieter: Eye Glasses to Cure Appetite. These goggles feature one rose-colored lens and one clear lens. Peering through the contraption supposedly inhibits the wearer's appetite.

- Slim-Skins Total Inch Reduction Program. This is the ultimate reducer for those excess inches in the waist, abdomen, hip and thighs. These plastic pants are complete with valve on the right hip that connects to a hose that plugs into a vacuum cleaner, which "sucks the air out of the pants so they are tight around you," Lindan



claims. As you exercise, you lose weight.

- Relax-a-cizor. This was designed with the couch potato in mind. You lie down in a bed and connect your body to a machine that has various pads. The machine is an electrical stimulating device that will cause muscles to contract electrically. So, the muscles work without any effort.

- Far Eastern Weight Loss Earring. Users can control their appetites simply by wearing the earring.

- The Facial Gym. This device improves your looks by exercising your face. A device resembling a plastic pair of scissors is placed in the mouth. Rubber bands are used to increase the tension as the user exercises by opening and shutting his or her mouth.

- Rheumatism cures.

Rheumatism sufferers were treated to a vibrating chair. "It shakes like mad when you sit on it," says Dr. Lindan. The idea was to loosen the joints.

All in all the good doctor has more than 1,600 items on private display in his Lyndhurst home outside of Cleveland. **OSMA**

Ohio Medi-Scene



Ohio ophthalmologists are improving elderly eyesight

Over the past five years, Ohio ophthalmologists have discovered 1,588 cases of cataracts; 157 cases of glaucoma; 336 cases of macular degeneration; and 66 cases of diabetic retinopathy — all in needy, elderly patients, many of whom, in the past, have left their conditions undiagnosed and untreated. The fact that these conditions are being caught today is due, in large part, to the National Eye Care Project, an information and referral service that was launched five years ago by the American Academy of Ophthalmology and is administered here by the Ohio Ophthalmological Society.

Lawrence J. Singerman, MD, OOS president, reports that the Ohio society has received more than 8,000 calls over the project's five-year existence and has referred more than 5,200 needy, elderly Ohioans to volunteer ophthalmologists across the state. These volunteer physicians provide a comprehensive medical eye

examination, then care for any condition they diagnose at no out-of-pocket expense to qualified patients. To qualify for a referral, the patient must be a U.S. citizen or legal resident, 65 or older, and without access to an ophthalmologist he or she has seen in the past.

Ohio's women MDs shine in leadership roles

More and more women physicians are rising to the top of their professions, observes an article that ran in a spring issue of the *AMNews* — and more and more of these top women leaders are coming from Ohio.

Four of the women who were quoted and pictured in the article are OSMa members: Bernadine Healy, MD, Cleveland, is President George Bush's choice to direct the National Institutes of Health, the first woman chosen for this position. Prior to this, Dr. Healy served as president of the American Heart Association; Antoinette Eaton, MD, Columbus, is president of the American Academy of Pediatrics; Claire V. Wolfe, MD, Columbus, chairs the AMA's Women in Medicine Advisory committee in addition to serving as a member of the Ohio delegation to the AMA and OSMa's Tenth District Councilor; and medical student Audrey Ludwig, Dayton, was pictured as one of the four women who serve on the AMA's Board of Trustees.

The article, which ran in the March 11 issue, closes with Dr. Wolfe's observations about



Healy



Eaton



Wolfe



Ludwig

women physicians and their new leadership positions in medicine. Although women physician-leaders are still considered pioneers, Dr. Wolfe says she hopes they won't be such a novelty in the future.

"The purpose of our committee (the AMA Women in Medicine Advisory committee) is to be non-existent in a few years," she says. "When we have as many women joining organized medicine and participating in leadership levels as do men, then our job is done." **OSMA**

Nationwide, more than 164,000 needy elderly have been referred to volunteer ophthalmologists, and more than a quarter-million have received information from the project's hotline. The toll-free Helpline number is (800) 222-EYES (3937). **OSMA**

Ohio Medi-Scene

Cincinnati DOCs take aim at car show

The Cincinnati Chapter of "Doctors Ought to Care" aimed its latest no-smoking message earlier this year at a nationally touring auto show, sponsored by a leading cigarette manufacturer.

In an effort to counter the show's cigarette advertising, aimed directly at teenage boys, DOC held a Youth Outreach Activity on the sidewalks outside, aimed at educating show-goers about the dangers of smoking. Nearly 30 DOC members and friends of DOC, wearing white coats and stethoscopes, passed out buttons and stickers and answered questions about cigarette smoking.

DOC participants hoped their outreach message convinced at least one teenage boy not to smoke, or to kick the habit if he already does. **OSMA**



Medicare tests new program in Cincy

Most Alzheimer's patients today are cared for in nursing homes at a cost of about \$30,000 a person per year. Custodial care would be cheaper, of course, but Medicaid is the only program that pays for such support services. Medicare does not.

That may change, however, if a new Medicare Alzheimer's Project, now being tested in eight cities around the country — including Cincinnati — proves to be successful.

The project is a three-year, government-funded study that offers a range of support services, worth up to \$550 a month, to families who provide care for family members with Alzheimer's Disease. Approximately 600 Cincinnati-area caretakers are

involved in the project.

The study's objective is to ease the burden of care and protect the health of caretakers while delaying expensive nursing home placement. The project's local director puts it this way:

"If we can delay nursing home placement by only six months, then it is cost effective." **OSMA**

Help meet the challenge

Recently, Cleveland-area physicians have been bringing television audiences up to date on new medical advances, thanks to a one-year-old program, "Medical Challenges," which airs on over 200 PBS stations, as well as locally on Channel 19, WOIO. Past programs have featured balloon angioplasty, the use of the hot tip laser for blocked arteries, the use of the IVUS in treatment of varicose veins, and drug and alcohol treatment services.

The show's producer is looking for other Ohio physicians who would be willing to discuss other challenges of medicine with which they may be personally involved. If you would like to participate on a future program, please contact the producer, M.R. Berger, (216) 831-4039. **OSMA**

Association News

Brochure informs patients about UHIO

Is the Canadian health-care system better than the American system?

The OSMA doesn't think so, and a new brochure, "Ohio's Uninsured: How We Can Solve the Problem," recently produced by OSMA's Communications Department, explains why. According to Carol Wright Mullinax, OSMA's Communications director, the brochure goes into detail on H.B. 175, the Universal Health Insurance for Ohioans (UHIO), which would replace all Ohio health insurance companies with a state-run health insurance system. OSMA strongly opposes the bill, favoring instead a combination of public and private sector reforms included in the AMA's Health Access America proposal.

You can help OSMA educate patients about the drawbacks of a Canadian-style universal health insurance system by displaying the brochures prominently in your office. The new brochures are available free, in unlimited supply, to all OSMA members. Also, for no additional charge a special display placard will be thrown in. At the time of this writing more than 40,000 brochures had already been mailed to Ohio physicians.

Another popular pamphlet, "Health Care Decisions," a patient guide to Ohio's Durable Power of Attorney for Health Care Law, has been available for the past year from OSMA's Communications Department. Requests have been overwhelming. It is estimated that the department has mailed more than 100,000 of these brochures, mainly to doctors' offices, hospitals, nursing homes and individuals during the past year. A

OHIO'S UNINSURED: HOW WE CAN SOLVE THE PROBLEM



recent write-up in a state publication resulted in an influx of mail. OSMA members may obtain these free brochures by contacting the Communications Department.

On the back burner is a living will brochure. Mullinax explains that if living will legislation becomes a reality, OSMA has discussed the possibility of working with the Ohio State Bar Association to produce a brochure to address this issue. Two living will bills drafted by the OSMA and the state bar association are currently being considered in the House Civil and Commercial Law Committee.

If you have any questions about ordering any of these brochures, contact the OSMA Department of Communications by calling (800) 766-OSMA. OSMA

Colleagues

C. William Keck, MD, Akron, is the first recipient of the Albert B. Sabin Award recognizing outstanding service to public health. The award was presented personally by Dr. Sabin. Dr. Keck has worked in the public health field since 1966, and has served as president of both the Ohio Public Health Association and the Association of Ohio Health Commissioners. He presently holds the position of president of the American Public Health Association. Dr. Keck has spent 14 years as Director of Health of the Akron Health Department, and is also the director of the division of Community Health Sciences at the Northeastern Ohio Universities College of Medicine.

John A. Devany, MD, Toledo, immediate past president of the OSMA, received the first annual "Outstanding Physician Award,"



presented by the Auxiliary to the Academy of Medicine of Toledo and Lucas County. The award honors capable, conscientious and courageous leadership in the medical profession for both the county and across the state. Dr. Devany was singled out for this year's award for "his realization that improved patient care entrails not only the traditional, caring and well-informed bedside manner, but also the willingness to exert influence in the public arena for appropriate legislation."

Association News

Auxilians meet with legislators

A freak ice storm didn't keep OSMA auxiliarians from attending their annual Day at the Legislature on March 13.

One hundred and thirteen auxiliarians, 17 medical students, 23 physicians and 85 legislators slipped 'n' slid their way to the Hyatt on Capitol Square in Columbus.

The reception and lunch is an opportunity most doctors and their spouses don't want to miss. What better opportunity to discuss their concerns with their personal legislators from the Ohio Senate and Ohio House of Representatives than this, says Evan Valassiades, third vice-president of the OSMA Auxiliary and chair of the event.

Legislators feel likewise. It's a great way for them to hear from their constituents.

On hand to share their political savvy were Sen. Grace Drake, Rep. Paul Jones and political analyst Charles Cook.

Cook jumped right in with some strong political advice. "An active, vocal minority is more effective than a passive majority," Cook emphasized. "It's important to know the different candidates, it's important for them to hear from their constituents. Get involved with your local campaigns," he stressed, while complimenting the work of the auxiliarians.

When not on the lecture circuit, Cook is editor of the *Cook Political Report* and a vice president in the Strategic and Economic Division of Hill and Knowlton, Inc., where he provides political analysis for its clients.

Health-care issues were addressed by both Sen. Drake and Rep. Jones. "We need to enhance the best health care in the world,"



Auxilians attend annual Day at the Legislature.

says Sen. Drake. "To do this," she continued, "we must use common sense and a realistic approach. Our marching orders must be good delivery and cost containment," she believes.

The present system is not as terrible as the public makes it out to be, says Rep. Jones. As he sees it, the present system is working for 87% of the population. The remaining 13% fall into several categories. There are: those who don't budget for health care, the working poor and the truly needy.

Rationing health care is not the answer. Neither is compromising quality. The answer seems to be preventative medicine. Rep. Jones believes more physicians need to become involved in this process. "It's time to take an inventory and find out what's working and what's not working. We need to find a cost that the government can work with," says Rep. Jones.

Also included in the day's activities was an AMPAC campaign school workshop. The four auxiliarians who attended the campaign school shared their knowledge with others. The school helps train those interested in

pursuing a political office and teaches the ins and outs of running a successful campaign.

"The Day at the Legislature was very successful this year. The speakers were excellent and so was the rapport developed among auxiliarians, physicians, medical students and legislators," says Valassiades, who adds that the inclusion of medical students in this year's event made the program interesting. "Good rapport was established between the legislators and medical students. The legislators became aware of the interest and commitment the young have to health care," she said.

The 238 in attendance was a far cry from the first Day at the Legislature some 15 years ago when 35 attended. The program has grown into one of the most successful and important functions sponsored by the auxiliary.

As a side note, because of the inclement weather last-minute cancellations were inevitable but no lunches went to waste. Valassiades instructed the kitchen to pack up the leftovers and deliver them to a nearby open shelter. **OSMA**

Where Are Medicine's Dividends?

UNITY, COMMITMENT ARE BEST INVESTMENTS

It is with great pleasure that I begin this year as Auxiliary President. As we enter the 21st century, there is a growing focus on value and effectiveness in medical care. While the 1980s saw some positive changes in health

care, many inequities still existed; and the 1990s will bring increasing scrutiny by government and payors. Accountability is now a part of medicine. No physician will rest on his or her laurels

and be successful.

It will be a decade of challenges and opportunities—a paradoxical time for medicine. It will be a time when hospitals and physicians are

subjected to restrictive cost controls and regulations, while technology expands rapidly, bringing with it growth and many more choices in the treatment of illness. Patients will grow in age and numbers, but the financial resources to fund their care will diminish. To succeed in this environment, we will make effective use of available resources, expanding, adapting and reconfiguring them. Our resolve must not be weakened from intrusions into the practice of medicine, but strengthened. Medical societies and auxiliaries need to foster the process of revitalization, motivating physicians to look ahead and strategically plan for their futures. We need a strong communications network with commitment from our staffs, physicians and spouses.

It is a privilege to work with the OSMA in developing and implementing plans that will make us successful. Creative talent abounds in the auxiliaries' ranks of 3,700. We are the greatest asset our spouses have and are able to assist organized medicine in multiple ways.

Auxiliaries are a diverse group with various personal goals. We all share, however, the bond of being

By Joyce E. Penn
OSMA Auxiliary
President



Auxiliary Page

physicians' spouses. Dr. Howard Lang, from California, spoke with the Academy of Medicine of Columbus and Franklin County this past winter. He reminded us to question our loyalties and allegiances. They must remain with the medical profession first, regardless of specialty or hospital affiliation. If we are divided, it will unquestionably weaken our strength.

The AMA and OSMA are not in competition with specialty societies or hospital medical staffs. Organized medicine needs their input and welcomes them. Physicians and spouses who become concerned with issues involving small segments of medicine tend to overlook the wide range of alternatives. Splintering the medical community into small interest groups will prevent us from confronting major issues affecting the entire practice of medicine. Consider the enormous influence we can all bring to bear as a unified group. There are many government agencies who would prefer that the medical community remain divided in pursuit of self interest.

I am struck by the reactions of friends as well as acquaintances I've met this past year while attending auxiliary functions. Many are hesitant to become involved, fearful of what they might be asked to do.

There are limits imposed by time in all our lives. Realistically, I feel that most alleged time problems betray commitments that we are trying to avoid. Medical society and auxiliary membership can involve as little as the time taken to write our membership checks or as much of our energy as we care to apply.

A 19th century physician and humanitarian. Dr. Albert Schweitzer, was known for his reverence for life. He once said:

"One thing I know: the only ones among you who will be really happy are those who will have sought and found how to serve."

Our spouses' profession, although satisfying and rewarding, demands a daily personal commitment with an enormous investment of one's energy. We, as spouses, share pride in the medical community and we must share the responsibility to strengthen the profession. As auxiliaries, we have been strong advocates of sound health legislation, health promotion and funding for health education. Representation in hospital auxiliaries and specialty

society auxiliaries is surely needed. Loyalty to the broader family of medicine, however, must take priority.

In this time of shrinking budgets and onerous legislation, we need to recognize that organized medicine is the best investment that physicians and their spouses can make, an investment with excellent dividends for the future. We must provide our support to enable medicine to maintain its margin of excellence, working for a better future for society, and for the families of tomorrow. **OSMA**

Editor's note: *The above article was drawn from the remarks made by Mrs. Penn following her installation as President of OSMA's Auxiliary.*

NEXT MONTH IN OHIO MEDICINE

- OSMA's 1991 Annual Meeting Report
- A look at living wills and durable power of attorney
- Medicare: Ohio physicians' attitudes and behavior
- The winning entry in the Medical Student Writing Contest

Legislation

“Don’t blame docs for state’s uninsured”

When the Ohio House appointed a new Select Committee on Health Care Reform to study ways to make health-care more accessible and affordable, the OSMA was one of the first groups to meet with the committee and voice an opinion.

That message, delivered by then-OSMA President John A. Devany, MD, was (with apologies to Shakespeare): “The fault’s not in ourselves, dear Brutus, but in the stars.”

Dr. Devany assured the committee, chaired by Rep. Barney Quilter (D-Toledo) that despite the state’s rapidly growing uninsured population, which now numbers 1.2 million (about 11% of the state’s population), doctors are *not* behind the spiraling health-care costs and should not be blamed. Nor should physicians be punished by a fee restriction, he said.

“The fact is, physicians’ fees are already restricted,” he told the lawmakers, pointing to the predetermined prices imposed by Medicare, Medicaid and other insurers as examples of physicians’ static income. He went on to tell the committee that this problem was being compounded by a burgeoning senior population and a rapid rise in new and expensive medical technology.

“Even if our charges were to be further restricted, the impact on health-care costs wouldn’t be that significant. Only 20% of the average health-care dollar goes to pay for physician services,” he said.

If anything *is* to blame for the state’s uninsured population, Dr. Devany continued, it is the changes in society that destroy health. He mentioned drug

addiction, teen pregnancy and fetal alcohol syndrome as a few of the more prevalent problems, and said most of these afflict a population that is least likely to have the money to pay for treatment.

Solutions are at hand, however, Dr. Devany told the committee. He submitted a list of remedial measures, recommended by the AMA, including one that mandates employers to provide insurance for employees and their families. Dr. Devany acknowledged businesses’ opposition to this plan, but said, “I feel that we can make it more palatable by offering employers tax incentives to provide insurance.”

He also recommended an expansion of Medicaid to include working families with incomes below the poverty level and he advocated risk-sharing among insurance companies as a means of providing coverage for high-risk individuals.



John A. Devany, MD, (right) OSMA immediate past president, testifies at committee.

Last month in his President’s Page, Dr. Devany wrote, “You will be hearing a great deal more as time goes on about this committee.” In the meantime, he asked OSMA members to learn who its members are and to keep abreast of its activities, “providing input when and where it is appropriate to do so.” **OSMA**

(See related chart on next page)

Legislation

A "Who's Who" Guide to the House Select Committee on Health Care Reform

The members of the House Select Committee on Health Care Reform are:

Rep. Barney Quilter
(D-Toledo) Chair
Rep. William Mallory
(D-Cincinnati) Vice-Chair
Rep. Judy Sheerer
(D-Shaker Heights)
Rep. Paul Jones
(D-Ravenna)
Rep. Mike Stinziano
(D-Columbus)
Rep. Robert Hagan
(D-Youngstown)
Rep. Wayne Jones
(D-Cuyahoga Falls)
Rep. Dean Conley
(D-Columbus)
Rep. Marc Guthrie
(D-Newark)
Rep. Rhine McLin
(D-Dayton)
Rep. Madeline Cain
(D-Lakewood)

Rep. Bill Batchelder
(R-Medina)
Rep. Bob Netzley
(R-Laura)
Rep. Bob Doyle
(R-Beavercreek)
Rep. Bob Corbin
(R-Dayton)
Rep. Ray Sines
(R-Perry)
Rep. Richard Rensch
(R-Milan)
Rep. Mike Fox
(R-Hamilton)

... And what bills they're considering

These bills are pending before the House Select Committee on Health Care Reform:

- House Bill 175** — State-administered health-care system (UHIO)
- House Bill 65** — Mandatory Medicare assignment
- House Bill 8** — Create state health insurance risk pool
- House Bill 113** — "Bare bones" health insurance for small business
- House Bill 169** — Child preventive care health insurance benefit
- House Bill 142** — Mammography screening health insurance benefit
- House Bill 127** — Mental health insurance benefit increase to \$1,000 annually

OHA survey shows universal health not that popular

What are the chances that a universal health insurance bill will pass in Ohio? If a Gallup poll, commissioned by the Ohio Hospital Association, is representative of general statewide opinion, the chances may not be as great as commonly believed.

James Castle, OHA president, said that his group was "surprised and pleased" that 59% of those polled said they would be willing to pay higher taxes to cover health-care costs for those who cannot afford insurance. Respondents, however, were opposed to increasing either sales or personal income taxes for this purpose. Instead, they favored raising taxes on alcohol and tobacco, using lottery profits and increasing fines for drunken driving and speeding.

The survey results are consistent with similar surveys Gallup has conducted nationally, but Ohio showed a higher approval rating for universal health care (47%) than other states, presumably because there has been more discussion on the subject here. Despite this, however, 71% of those polled supported keeping but modifying the existing system of both private insurance and government-paid health care and 89% favored a measure requiring all employers to provide health-care insurance for employees.

The telephone poll surveyed a demographic mix of 800 heads of households across the state. The OHA plans to share the survey's results with Gov. Voinovich and state lawmakers, Castle says. **OSMA**

Legislation



Corporal punishment bill is back

Like swallows to Capistrano, or buzzards to Hinckley, some legislation returns again and again to the Statehouse — in different form, perhaps, but the intent seems always to be the same.

This session, back for a repeat appearance, is a bill dealing with corporal punishment in schools.

State Sen. Dick Schafrath (R-Wooster) has introduced, for the third time, a bill that would prohibit corporal punishment in schools, unless a local district adopted a formal policy permitting its use under mandated state guidelines. The bill, Senate Bill 86, was introduced in the Senate Education Committee in late March, and has OSMA support.

"Both the OSMA and the AMA have policies against corporal punishment of any kind. This bill, a political compromise, is the next best thing," says Cynthia Snyder, Associate Director of OSMA's Department of Legislation.

Sen. Schafrath introduced similar legislation last year, and his bill was passed by the Ohio Senate. However, it ran out of time in a House committee. His new

bill specifically prohibits corporal punishment in Ohio, effective September 1, 1992, unless a school board legislates corporal punishment as part of its system's disciplinary policies. Such local legislation would have to include:

- A recommendation from a task force appointed to develop a system disciplinary plan.
- Specific make-up of this task force would have to include: a principal, a teacher, a parent, a pediatrician and a child psychologist.
- At least one public hearing by the task force, which would present its findings no later than July 17, 1992.

SB 86 would affect public schools only. Private and parochial schools would be exempt.

Ohio commission promotes minority health

Although Minority Health Month was two months ago, Richard E. Spencer, Jr., Associate Director of the Commission on

Minority Health, wants to remind you that the program is alive and well and continues to wrestle with the state's minority health problems.

According to Spencer, Ohio was the first state in the nation to examine the health status of minorities, a move that was prompted by a mid-1980s U.S. Department of Health and Human Service report that reflected a disparity between the health of America's minority and non-minority populations. The Ohio study, conducted by the Governor's Task Force on Minority Health, revealed that the state's African-American, Asian, Hispanic and Native American Indian populations experience a disproportionate number of premature deaths from preventable diseases. The General Assembly formed the Ohio Commission on Minority Health to tackle the problem.

Since then, eight other states have fashioned minority health programs after the Ohio model, and the Disadvantaged Minority Health Improvement Act, which passed last year, guarantees that more state minority health programs will be up and running soon.

The Ohio Commission's principal project at this time is helping to bridge a communications gap that keeps health-care messages (aimed at a general audience) from reaching minorities.

Anyone wishing more information about the Commission on Minority Health may contact Spencer at 77 S. High St., Suite 745, Columbus, 43266-0377, (614) 466-4000. OSMA

Legislation

Rural communities' scramble for doctors could end

In January, *OHIO Medicine* brought you the story of how the state's rural communities are scrambling for doctors. Now, a piece of legislation may help ease the MD shortage in *all* underserved areas, including outlying rural districts.

Senate Bill 83, sponsored by Sen. Robert Ney (R-Barnesville) would create a state loan repayment program for primary care physicians who agree, in turn, to provide primary care services in those areas of the state that are designated by the Ohio Department of Health as "health resource shortage areas."

An identical bill was passed by the Ohio Senate last year, but the House failed to take action on it.

"The legislation takes a pilot-project approach," says Cynthia Snyder, associate director of the OSMA's Department of Legislation. "The object is to get primary care out into areas where such service is not presently available." As Snyder explains, an underserved area could just as easily be an inner city district as a rural one.

The proposed program is similar in purpose to the federally funded National Health Service Corporation, which provided scholarships to medical students who agreed to work in medically underserved areas upon graduation. The program was scaled back when a study indicated a surplus of physicians in the program. The study, however, did not reveal that many of these students were going into



specialties, creating a shortage of primary care physicians, nor did it take into consideration the retention of these physicians once their terms of service were up.

Even the program proposed by SB 83 can't guarantee that similar retention problems won't occur. "However, the National Health Service proved to be successful at placing physicians in these areas, and even if a physician left after his or her term of obligation, a replacement usually followed," says Snyder. She believes the same would occur under the proposed state Physician Loan Repayment Program. The OSMA actively supports this legislation. **OSMA**

Cancer, trauma registries around the corner?

Is Ohio closer to establishing a centralized cancer registry? If House Bill 213 sponsored by Kate Walsh (D-Oberlin) is passed, a cancer surveillance system for the state would be put into place at the Ohio Department of Health. The ODH would collect data from local cancer registries, and conduct demographic studies based on the statewide statistics. The studies should help researchers determine, among other things, the types of cancers most prevalent in the state, and whether or not there are concentrated areas of cancer. The Ohio Department of Health and OSMA's Cancer Committee worked for several years to develop legislation for a cancer surveillance system. Funding the system will cost approximately \$850,000 a year. OSMA supports the bill.

Also in the works is a trauma incidence reporting system, proposed under Senate Bill 98, sponsored by Sen. Bob Ney (R-Barnesville). This bill would create a State Board of Emergency Medical Services, which would be required to establish, in turn, an Emergency Medical Services Incidence Reporting System. This system would collect information on the delivery of emergency medical services. The board would also be required to establish a Trauma System Registry for the collection of information regarding the care of trauma victims. OSMA also supports this bill. **OSMA**

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Practice Management Directory expands

It's back! The Practice Management Directory, compiled by OSMA's Ombudsman department and distributed earlier this spring, has been expanded.

The booklet, which contains information about companies that provide various business services to the medical community, received such overwhelming interest from others who wanted to be included, that the Ombudsman staff decided to print another directory immediately. Plans now are to update the directory on an annual basis.

If you would like a copy of the new, expanded directory, contact the Ombudsman staff at (800) 766-OSMA, ext. 215. There is no charge to OSMA members. OSMA

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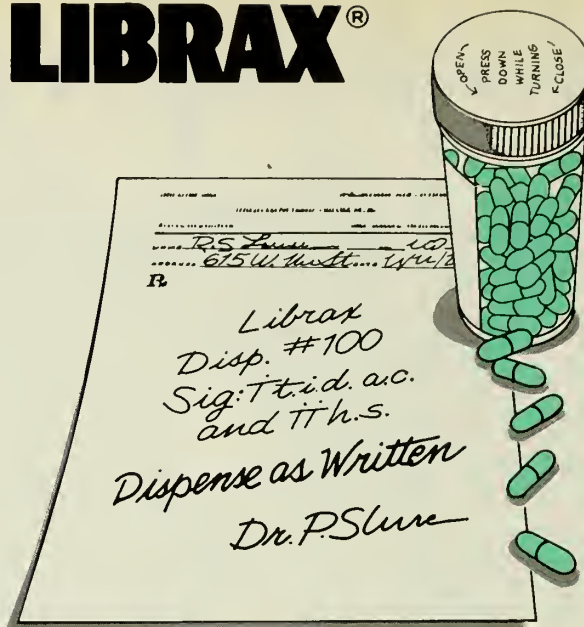
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Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary.

Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

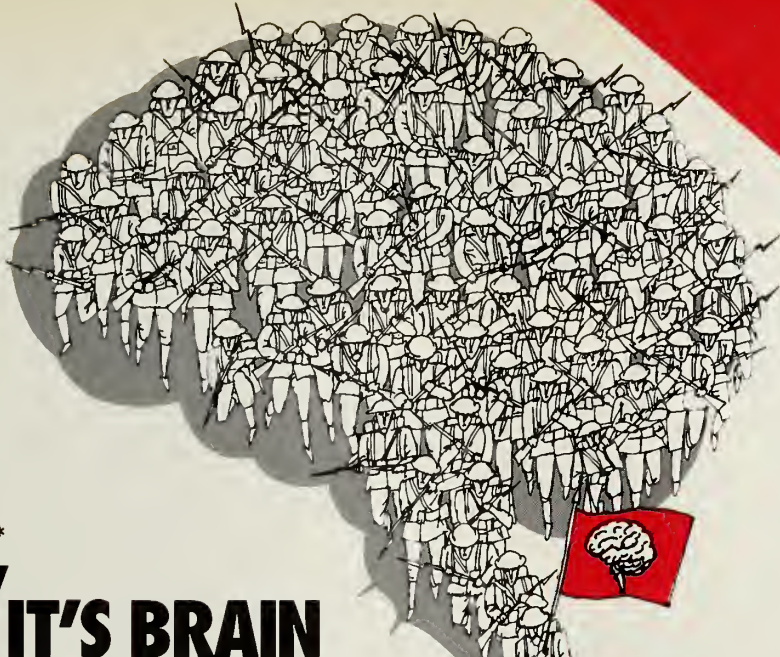
Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Revised: February 1988



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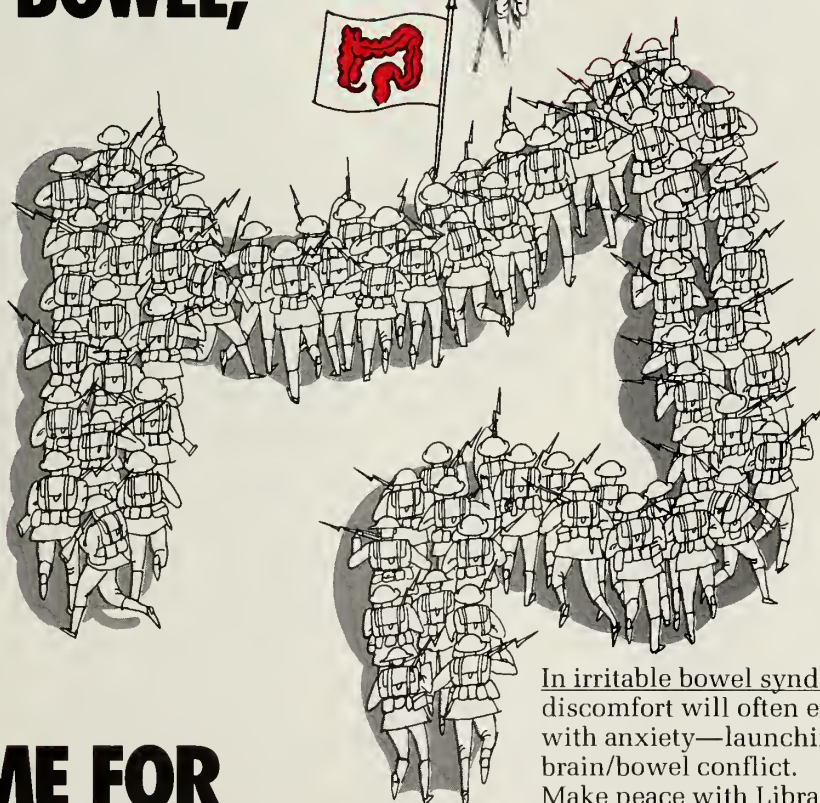
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COVER STORY

The Sudimack Agenda

New President Wants OSMA “Lean And Mean”

OHIO Medicine recently had an opportunity to speak candidly with Joseph Sudimack, Jr., MD, the new OSMA President. This busy and dedicated clinician has served in a variety of capacities at the OSMA during his 30-year tenure ranging from Sixth District Delegate to Secretary-Treasurer before assuming the position of president. Dr. Sudimack recently took some time from his busy schedule to shed some light on the future of OSMA and what's in store for medicine. Below are his comments.

Q. Why did you decide to run for office? What unique qualities do you have that qualify you for this job?

A. Boy, that's a humdinger. Medicine is one of the original, most honorable professions of the world in my opinion. I wanted to participate in such a fine, outstanding profession to the utmost — running for office would do that for me. I have a sincere and deep desire to continue to provide the best possible patient care in Ohio, and I hope as OSMA President I can make this goal achievable, while communicating to society that the

medical care they receive is outstanding.

The unique qualities I bring to this job is my diversified background. I've worked as a solo practitioner, occupational medicine practitioner and as an elected government official. I know the ins and outs of government, industry and private practice. I've been exposed and associated with all three spheres. This experience in dealing with labor unions, third parties and businesses can only help me in facing and understanding the needs of the OSMA membership.

Q. How would you answer those who ask, “What has the OSMA done for me?” What has the OSMA done for you?

A. I believe the OSMA has kept its membership current regarding actual and contemplated changes in the medical health-care delivery system. In addition, OSMA provides updated information on legislative issues, patient care, and provides ombudsman services for third-party problems. OSMA represents the medical profession to the press, business and private constituency groups. It guides physicians in providing quality care. Additionally, OSMA has

constant dialogue, and works with, medical schools, state agencies and federal government, always with the practitioner in mind. OSMA provides its membership with up-to-date scientific information regarding the latest in new technologies and procedures and medical concerns in general.

For me, OSMA has done all of the above and more. Particularly, it has provided me with a forum where I can be heard and discuss issues that I'm concerned about with other physicians. And, I actually participate in solving problems and improving the quality of care.

Q. The OSMA has been looking at long-range plans and future growth of the association. Without tipping the OSMA's hand, how will these plans enable the OSMA to better serve its members in the future? Why was this long-range planning undertaken?

A. We are in a time of socioeconomic change. In this regard our organization has to be flexible and establish priorities. There are economic issues that need to be discussed. If we want to maintain our position of strength we must be lean and mean. We need to respond more quickly to the membership. We need to act as minutemen with regard to issues that threaten patient care. That's the reason the long-range planning committee was undertaken, so that we could adapt to these rapidly changing times. And the trick is to incorporate these changes without raising dues, while providing these services and more. We need to be responsive to members' needs. The solo practitioner depends on the OSMA for guidance and support. Perhaps by broadening the kinds of services the OSMA provides to include services needed by the medical communities associated with PPOs, HMOs, salaried and academic practitioners, we could unify and increase our membership. I'm sure we have

something to offer all of these groups.

Q. Do you have goals, things you'd like to accomplish during your year in office? What are they?

A. I believe the physicians and the health-care system are doing an outstanding job in Ohio. I would like to see us maintain or better yet increase the quality of care being offered and broadcast these facts to one and all. We need to be at the table and help solve the social problems that are present in this country. We offer the best medical care in the world. We need to keep going. We can't stifle it. We must participate in the evolution, but not allow a revolution, in medical care.

Q. You've been a member of the association for more than 20 years. How has the association grown since you've been a member? Has it made a difference in influencing medicine in Ohio?

A. Probably the biggest change I've noticed since joining the association in 1960 is the increase in total membership and change from general practice or family practice domination along with a concomitant increase in female members. The services provided by OSMA are remarkable — especially the addition of the quality staff, primarily in the legal and legislative areas. The specific services available to members are outstanding. All of this has made a significant and definite difference in influencing medicine. We are much more attuned to maintaining economical quality care, which requires physician participation. We've supported and encouraged all specialty areas, such as sports medicine, emergency physicians et al, to take a more active part in the association. Individual physician contact with the Legislature, guided by the OSMA, has provided our legislators with information to help in their deliberations.

Q. In your opinion, what are the three single most important issues facing medicine today?

A. I'd have to say the three most important issues facing medicine are: cost, access for the under- or uninsured, and the real possibility of rationing of health care.

Q. If you could have an hour with Gov. Voinovich, what would you spend your time discussing?

A. Let me think about that a moment. I'd emphasize quality of care and individual responsibility. Probably, I'd focus on the problems addressing health care in the state of Ohio and that portion which needs to be fixed. The government officials' view of health-care issues is money-driven. I'd try to persuade the governor that this is tunnel vision and can lead to disaster. We have to balance the quality of care individuals are receiving along with costs. Patients are not automobiles, they can't be put on an assembly line; they must be dealt with as individuals, with the respect and dignity they deserve. I'd elaborate on the fine technology available in Ohio hospitals. Lastly, I'd expound on the fine quality of education offered to young medical students here in the state.

Q. What three reasons would you give a non-member for joining the OSMA?

A. One, I'd try to persuade them that we need them as members, reasoning that we'd do a better job of representation if we were united and were able to speak for 100% of Ohio physicians. If most of the physicians in Ohio became members of OSMA, we would be comparable to EF Hutton in that they would listen! Secondly, I would share with a prospective member the personal services available through OSMA. Many of the services I've already elaborated on in previous answers. Thirdly, I'd encourage participation in the Ohio Medical Education and Research Foundation (OMERF) —

Continued on page 288

About OSMA's New President



*Joseph Sudimack, Jr., MD
OSMA President*

Medical Specialty: Occupational Medicine

Current Position: Medical Director for the Ohio Bureau of Workers' Compensation; and interim director for the Ohio Bureau of Workers' Compensation — Rehabilitation Division

Personal: Resides in Columbus with wife Linda; seven children

Education: B.A. Ohio State University, 1949
M.Sc. Ohio State University, 1952
M.D. Ohio State University School of Medicine, 1956

Medical Training: Internship: Lankenau Hospital in Philadelphia
Mini-residency: The University of Cincinnati's Institute of Environmental Health and Kettering Laboratory

Experiences:

- 21 years solo practitioner in Warren;
- Trumbull County Coroner from 1960-1987
- 20 years as district physician for Republic Steel Corporation, Mahoning Valley District
- Served as medical director of the J. Leonard Camera Industrial Rehabilitation Center in Columbus
- Served as medical adviser of the Rehabilitation Division, Industrial Commission of Ohio

Professional Memberships and Offices Held:

- American Medical Association (Alternate Delegate 1982-1986; Delegate 1986 to present)
 - Ohio State Medical Association (Delegate 1976-1986) (Secretary-Treasurer 1985-1990) (President-Elect 1990-1991) (President 1991-1992)
- Trumbull County Medical Society (Past President)
- Trumbull County Academy of General Practice (Past President)
- Academy of Medicine of Columbus and Franklin County
- American Public Health Association
- Fellow of the American College of Preventive Medicine (April 1983)
- Fellow of the American College of Occupational Medicine
- Certified "A" Reader by HEW for Black Lung Disease
- Ohio State Coroners Association (President 1981-1982)

Community Organizations and Activities:

- Ohio State University County Alumni (President 1977-1978)
- Ohio State University Athletic Committeemember
- Warren Area Chamber of Commerce (Vice President 1986)
- United Way of Trumbull County (President 1985-1986)
- Health Systems Agency of Eastern Ohio (Treasurer 1984-1986)
- Coalition for Cost-Effective Health Services (Columbus)
- Warren Area Jaycees Civic Award for Outstanding Community Service (1985)



Joseph Sudimack, Jr., MD (left) with Donavin A. Baumgartner, MD, OSMA Past President, during last year's annual meeting.

what a wonderful opportunity for physicians to assist colleagues and medical students.

Q. Where could the association stand improvement? (Where are its weaknesses?)

A. I don't feel we've adequately counteracted the massive media attack on health-care cost. Physicians and the public need to realize that high health-care costs are not due to the physician. A physician's main concern should be providing the best possible care, although it appears that society wants cost to be included in the equation. In general, physicians are not viewed in a favorable light by the media. Physicians as a group volunteer and contribute a great deal to their patients and community. Typically in order to sell newspapers the media jumps at the chance of broadcasting the negatives. The public needs to be educated as to how much good physicians actually do. I think it's time for the association to bolster their physicians' morale. We have been maneuvered into fighting many of our battles on the economic battlefield. We need fair fees to survive, but we should try to avoid money issues that make us appear self-serving. We are patient advocates, that's our primary concern. The battles that we fight should deal with public health issues such as smoking, drug abuse, AIDS and quality of care, for example. The costs of medical procedures, reimbursement, etc. are difficult to win in the present hostile environment, but I believe this will change if we restore our credibility as patient advocates and educate the public accordingly.

On the whole I think we do a good job as an association. Much of that is due to the terrific staff that we have. When I compare OSMA to other state associations, I think we are very fortunate. We do a good job of getting

information out to our membership. But, like everything else, there's always room for improvement.

Q. What is medicine's future? Where is it going? How will the association be able to guide this direction in the future?

A. I think medicine's future is grand and glorious! I'm a total optimist. Never, in the history of mankind has a learned profession been able to accomplish so much for so many. I see the future of medicine finding a cure for cancer like it did polio, once thought of as a non-curable disease. The procedures and technologies still to come will be mind boggling. I continually encourage students and youngsters, including my own, to enter what I consider the most noble profession.

Through strategic planning the association will be able to position itself to guide the direction of medicine in the future. We must be attune to the times and more accordingly to our membership. We must respond to and answer

the demands and challenges of society.

Q. What changes that have taken place in medicine irritate you the most? How would you solve these issues if you could?

A. Hassle factors and intrusion are what disturb me the most. I mean the third-party challenges (interference). The amount of time that is spent with third parties to get approval is one of the worst. We need to improve our dialogue with the United States government. We have to become responsive to the political pressure forced on us and stand up and be counted. A proactive mode is in order. We must build strong coalitions among health professionals and work together to assure quality care for our patients. It's going to take us applying our own political pressure and effective use of our sphere of influence. And, I believe that with knowledge and truth we can get back on track and forge ahead and continue to provide "good medicine" for the people of Ohio. **OSMA**



Joseph Sudimack, Jr., MD, reviews X-ray with Rosemary Reid.

Shooting down the courts' "hired guns"

In some circles, they are called hired guns. They are the expert witnesses who travel from state to state, tailoring their testimony to the case at hand.

For the past year, OSMA's Task Force on Professional Liability, chaired by Arnold G. Schuring, MD, has been studying the problems inherent in an expert witness system where one phone call can produce a physician-expert in any specialty to testify against you.

The problems, however, are not easy ones to tackle. Expert witnesses may be just that.

"When the committee looked at the list of physicians who have served as expert witnesses, we saw the names of colleagues and professors who taught us in school," says Dr. Schuring.

As he points out, there are plenty of physicians who quietly present expert testimony out of a sense of fairness, and who accept no remuneration for their services. On the other hand, there are also plenty of other experts who abuse the system, who use it as an income-generating source, or who simply believe they know best and can make judgments for others. Often, these experts change their testimony to suit the case. These are the experts the OSMA Task Force wanted to expose, yet the dramatic dichotomy of experts makes a solution difficult to find.

"We looked at rating testimony, and at having our committee look at the qualifications of those experts we were upset with," says Dr. Schuring. In the end, however, the Task Force felt those approaches were too judgmental.

"We also knew whatever approach we took had to be organized on the national rather



than state level because that's where these experts were coming from," Dr. Schuring continues.

The task force finally concluded that the best solution was an expert witness repository program, which they would encourage each national specialty organization to develop.

As Dr. Schuring explains it, the repository is a library where depositions and testimony from both defense and plaintiff expert witnesses would be held without comment. Then, if a physician is sued, and an expert witness is called to testify against him or her, the physician-defendant could make a call to the specialty society's repository.

"The specialty society would send to the member a copy of other testimony that expert witness has provided in the past," says Dr. Schuring. That testimony could then be studied by both the physician-defendant and his or her attorney.

The American Association of Neurological Surgeons already has such a repository in place, and the Academy of Otolaryngology — Head and Neck Surgery (where Dr. Schuring is an active member) is also considering initiating such a program. As far as the OSMA task force is concerned, however, these two specialties are not enough.

So, this past winter, the task force, under Dr. Schuring's signature, sent letters to each national specialty society, asking them to consider establishing an expert witness repository program for their members. Just over a month after those letters went out, responses began to come in. Almost half a dozen have been received so far, and all have expressed interest in the project, but Dr. Schuring would like an even greater response.

If you would like more information on this program, for yourself or for your specialty group, contact Dr. Schuring at: Otologic Group, 3983 East Market Street, Warren, OH 44484, (216) 856-4000. **OSMA**

Two new MDs join medical board

Gov. George Voinovich has appointed two new members to the Ohio State Medical Board. Anand G. Garg, MD, a Youngstown neurosurgeon, will serve a five-year term, replacing Jonathan Ross, MD, Toledo, whose term has expired. Robert S. Heidt, Sr., a Cincinnati orthopedic surgeon and medical adviser to the Cincinnati Reds and Bengals, serves a three-year term, replacing Judith Daniels, MD, Cincinnati, who resigned. **OSMA**

Legal

Bad news/good news about economic credentialing

The bad news is that economic credentialing is in Ohio. The good news is that the OSMA is doing something about it.

For those who missed the seminar on economic credentialing presented in Columbus earlier this year, or the OSMA-HMSS Educational Session on the subject held last month during the OSMA's Annual Meeting, economic credentialing is *not* quality review. Patient care is the bottom line in quality review. In economic credentialing, the hospital's profit-and-loss statement becomes the bottom line.

Economic credentialing uses non-quality-based economic factors as a consideration for appointing — and reappointing—staff members. Your appointment could hinge on such factors as the percentage of charity care you provide; your acceptance of certain insurance plans; your age; what percentage of Medicare/Medicaid patients you see; and the number of patients you bring into the facility. The economic credentialing process can include the use of medical staff development plans, as well as the use of exclusive contracts, medical staffs and departments. (Next month, *OHIO Medicine* will carry a report from the OSMA-HMSS Educational Session on this subject, so watch for it.)

As disturbing as this process sounds, there is a way for medical staff applicants to protect themselves, and that is to update their hospital staff bylaws — altering them so that economic factors are not a basis of

qualification. The OSMA Model Bylaws Review committee is currently drafting provisions to protect medical staff members against this process, and it hopes to have them available by next fall. **OSMA**



How lucky can MDs get?

Right now, the only health-care professionals that are being reported to the National Practitioner Data Bank are physicians and dentists — despite the fact that, under Section 5 of the Medicare/Medicaid patient protection statute, “all licensed health-care practitioners” fall under the same reporting requirements.

Blame the delay on large projected set-up costs, which the Department of Health and Human Services (DHHS) says will delay

the reporting on these practitioners into the “foreseeable future.”

The National Practitioner Data Bank, which began collecting information on physicians and dentists last September, has far exceeded its original budget estimates, says the DHHS. It plans to raise the cost of querying the data bank from \$2 to \$6 to help offset costs. **OSMA**

Ohio Medical Board tackles fee reviews

Should physician fees be reviewed and, if so, *who* should review them?

The question is one the OSMA has wrestled in the past. Now, the Ohio State Medical Board has decided to tackle the problem.

Joan Wehrle, the board's Public Inquiries Officer, says that the board's interest in fee review has found new focus because of the Public Inquiries Division, a department of the board established in September 1989.

“Our job is to answer inquiries that come in from the public. We help the caller determine whether or not it is necessary to file a complaint with the medical board or we refer them to another state agency, such as Workers' Comp or Medicare, if that would be more appropriate.”

Lately, Wehrle and her staff have been able to accomplish what the board has lacked the resources to do in the past; compile the patient complaints and analyze their nature. Of 1,654 total complaints received by the board last year, 7% dealt with physician fees.

Legal

That was enough to prompt the board to form a task force to look into the matter. Chaired by board member Thomas Gretter, MD, Cleveland, the task force is composed of board members and representatives from various professional associations, including the OSMA and the Cleveland Academy of Medicine. The Cleveland Academy was asked to participate because it is one of the largest county medical societies performing physician fee review.

The task force held its first meeting last July, and has met once this year — in January. Its next meeting will be held this month.

"We are still trying to determine the scope of the problem," says Wehrle, when asked about the task force's progress. The board has surveyed other state regulatory agencies nationwide to see if a precedent for physician fee review has been set, and learned that 11 state Boards currently have statutory authority to perform such review. Most of the complaints come to these agencies through "unprofessional conduct" complaints, or complaints on some other ethical grounds.

The board's task force is not necessarily seeking statutory authority to do physician fee review, says Wehrle. It is one of many options the task force is reviewing. Other options include: increasing patient education about fees; enhancing physician communication about fees (one suggestion calls for doctors to provide information about their fee schedules to patients); and educating office staff about proper coding.

"Many of the complaints we see come about after the patient's bill has been sent to collection," says

Wehrle. Other complaints come after hospitalization — usually, because the patient didn't understand there could be separate bills for anesthesiology and laboratory services. Patients also complain when they are balance-billed. "Sometimes, a complaint comes in and we learn a legitimate clerical mistake has been made," says Wehrle. These are easy to rectify — but the matter of physician fee review is not.

"It has become a complicated issue to resolve," says Wehrle.

A more detailed analysis of the fee complaint letters sent to the Board is now under way to determine whether or not there are any trends the task force might address at its meeting this month. It may also consider referring fee complaints to county medical societies to investigate *before* the board reviews them.

Katrina English, JD, OSMA's staff counsel and liaison to the Medical Board, says that antitrust laws make county medical society review difficult unless specific guidelines are followed.

Currently, the State Medical Board only becomes involved in a physician fee dispute if there is evidence of fraud. Whether that involvement will be expanded in the future is what this task force is about.

"Our ultimate goal," says Wehrle, "is to determine how best to help consumers and physicians resolve their differences over fees." OSMA

Fee before regs? The new troubles with CLIA

Background

It's law, but no one seems to be enforcing it.

Three years ago, Congress, promoted by reports of inaccurate medical tests performed by unregulated labs, passed the Clinical Laboratory Amendment of 1988 (CLIA '88) which established strict regulatory standards for laboratories.

In many instances, physicians, including some here in Ohio, reconsidered operating in-office laboratories, unsure as to whether or not the extra time and expense required to meet the new, stringent requirements were worth the convenience of having a lab on site. Some believed it was not, and shut down their laboratories.

Now, however, the law that promoted those closings languishes for lack of enforcement. According to an article in the *New York Times*, federal officials and members of Congress suggest three reasons for the delay:

- The Department of Health and Human Services does not fully understand the tests performed in clinical laboratories, and therefore has difficulty writing technical standards.

- The department has not devoted enough personnel or resources to the task.

- Some critics go so far as to say the administration, particularly the White House Office of Management and Budget, has never been enthusiastic about the law and is trying to undo, through regulations, what Congress did through legislation.

Federal officials estimate that

Legal

there may be 100,000 laboratories in physicians' offices, and anywhere from 300,000 to 600,000 laboratories overall. The White House Office of Management and Budget says that the government would need \$540 million a year in fees to cover the costs of enforcing the law.

Of course, the law *is* still on the books and physicians who continue to operate in-office laboratories without conforming to the strict requirements set forth by the three-year-old law do so at their own peril.

As to when the law will be actively enforced, no one seems to be sure. The Health Care Financing Administration's original rules for the regulation of clinical labs met such vehement protest from state and national medical groups, including the OSMA, that the agency is presently rewriting the rules.

A new twist

In the meantime, and before these new rules are available, HCFA has announced its intentions to collect a preliminary \$261 fee for the registration of physician labs. Doctors must pay the fee and obtain a provisional certificate by the first of next month if they continue to provide laboratory services. This means that the fee is due *before* physicians and laboratories receive the information with which they will determine whether or not to continue to offer lab services.

OSMA action

The AMA and the OSMA have taken the position that attempts to collect this fee before regulations are published are unfair and contrary to the intent of the Administrative Procedures Act.



Both the AMA and the OSMA have written to members of Congress, requesting their support for the postponement of this fee collection until the revised regulations are published by HCFA. In addition, the OSMA has written to specialty society presidents, requesting them to take similar action.

In his latest budget request, President Bush said that the administration would re-examine the issue of regulating laboratories in doctors' offices. HCFA's new rules, then, may never get off the ground, which makes the upfront fee collection even more offensive.

The OSMA Department of

Professional Relations and Ombudsman Services continues to monitor the government's activities concerning CLIA '88 and will advise OSMA members of any changes. If you have questions, contact Deborah Bahnsen at the OSMA, (800) 766-OSMA. **OSMA**

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Fact #2:

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*Source: Consumer Reports May 1988

**Source: U.S. News and World Report February 9, 1987

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PEER REVIEW

NEEDS YOU

The next time you criticize the regulation of health care, think about the airline industry and how public pressure and grassroots advocacy have

transformed it during the last 15 years.

Airplanes transport thousands of passengers everyday. Most passengers don't dwell on the likelihood of mechanical problems, but concern themselves with arriving at their destination

on time. Unfortunately, despite years of pilot experience, the furious activity of the ground crew and the sophistication of air traffic control, airline disasters do happen. Predictably, these events

have aroused public concern about safety and quality in the airline industry and sparked demands for safety information. Such public concern has prompted the federal government to increase its regulatory activities in this area to provide the consumer with airline safety records and other information. The motivation for regulation in the airline industry may have stemmed from concern over safety, but the passenger eventually becomes interested in connecting cost to safety and using this information to assist in the selection of air carriers.

Like airline passengers, patients want to be informed consumers of health care. Patients are requesting more detail about their medical conditions — not just treatment or prognosis, but value and cost. Unfortunately, bad outcomes, like crashes in the airline industry, occur in health care. Bad outcomes in health care provoke concerns from the public. Consumer advocate groups, the media and lawyers feed upon these concerns and sometimes offer "solutions" that may not always be in the best interest of those they are designed to help. Out of "concern" for health-care consumers, advocate groups target physicians who are a few days late paying their license renewal fee; prepublication access

Continued on page 298

**By D. Bradley
Seitzinger, MD**

**Assistant Vice
President of
Medical Affairs
at Peer Review
Systems, Inc.**



Obituaries

WALTER FANELLI, MD, Cleveland; Case Western Reserve University School of Medicine, 1926; age 89; died March 16, 1991; member OSMA and AMA.

NANCY K. ELLIS, MD, Bedford; Case Western Reserve University School of Medicine, 1970; age 50; died March 13, 1991; member OSMA and AMA.

SAMUEL E. FLOOK, MD, Dayton; Ohio State University College of Medicine, 1929; age 84; died April 2, 1991; member OSMA and AMA.

LOUIS M. FRIEDMAN, MD, Toledo; St. Louis University School of Medicine, St. Louis, MO, 1932; age 84; died March 12, 1991; member OSMA and AMA.

HEISE, ALVIN L., MD, New Madison; University of Cincinnati College of Medicine, 1954; age 67; died March 31, 1991; member OSMA.

HOWARD M. HUNTER, MD, Hamilton; Ohio State University College of Medicine, 1938; age 82; died March 23, 1991; member OSMA and AMA.

ALTHENA KING, MD, Cincinnati; Medical College of Pennsylvania, Philadelphia, PA, 1953; age 63; died March 27, 1991; member OSMA.

WILLIAM MAHONEY, JR., MD, Cleveland; Case Western Reserve University School of Medicine, 1958; age 60; died March 9, 1991; member OSMA and AMA.

MYRON MEANS, MD, Sylvania; Rush Medical College, Chicago, IL, 1930; age 89; died February 15, 1991; member OSMA and AMA.

JOHN B. McCOY, MD, Elyria; University of Iowa College of Medicine, Iowa City, IA, 1955; age 60; died April 7, 1991; member OSMA and AMA.

WILLIAM McELROY, MD, Bradenton, FL; University of Cincinnati College of Medicine, 1929; age 89; died April 5, 1991; member OSMA and AMA.

WILLIAM A. SIMMONS, MD, Canton; University of Maryland School of Medicine, Baltimore, MD, 1957; age 59; died March 11, 1991; member OSMA.

STANLEY D. SIMON, MD, Cincinnati; University of Cincinnati College of Medicine, 1925; age 89; died March 4, 1991; member OSMA and AMA.

CHARLES WALTNER, MD, Youngstown; Orvosi Fakultás Tudományegyetem, Budapest, Hungary, 1932; age 82; died January 16, 1991; member OSMA and AMA.

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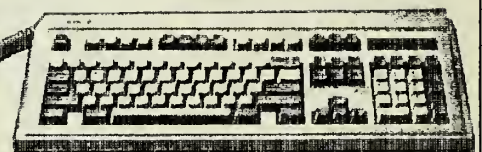
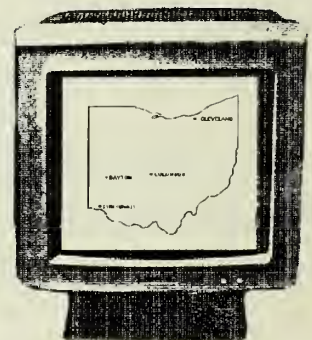
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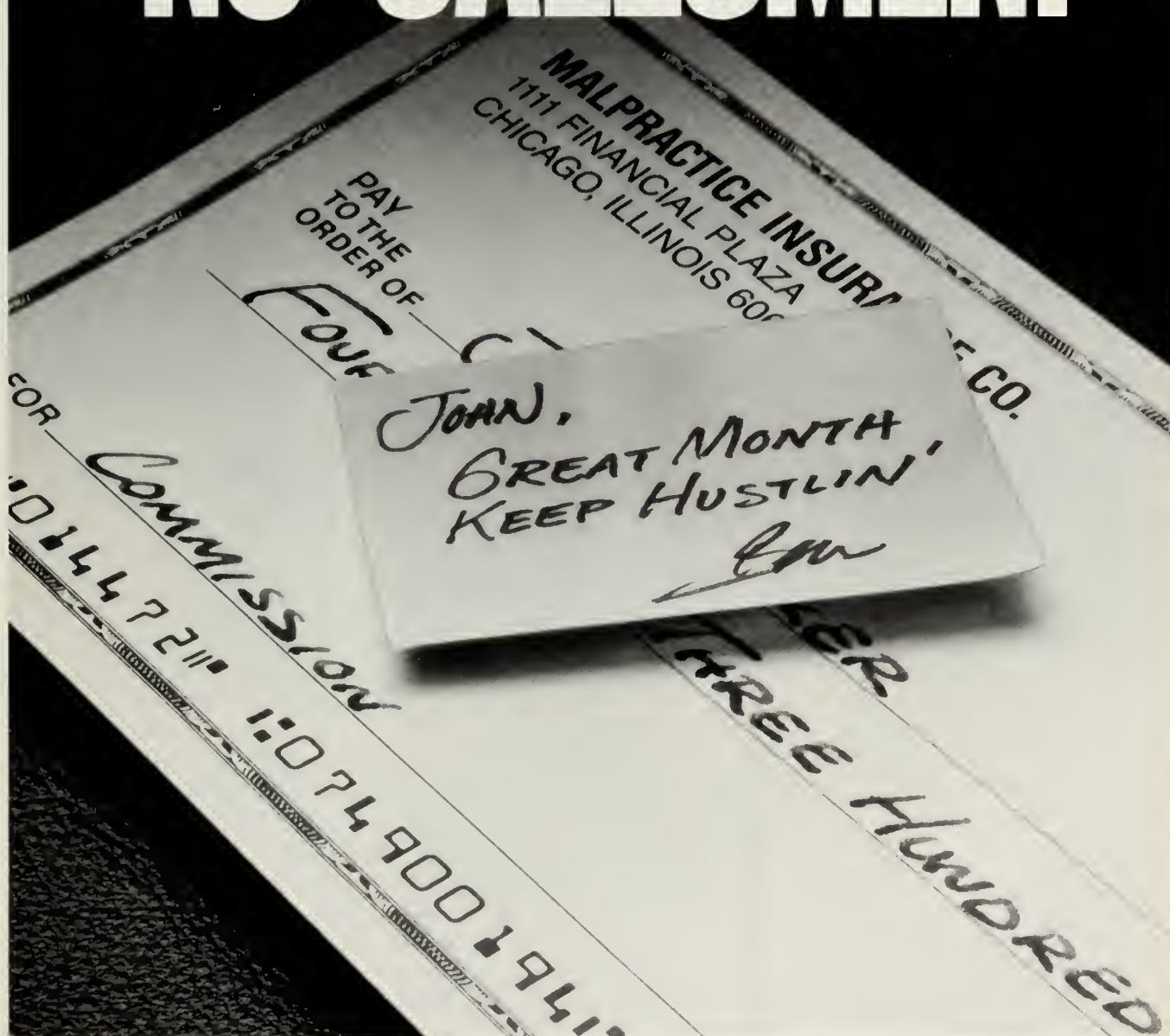
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Peer Review

by the media of journals or meeting abstracts allows premature opinions to be formed by patients; and the legal profession feels obligated to define the practice of medicine.

It is inevitable that the evaluation of health-care goods and services *will* occur in this country. Each of the previously mentioned groups feels strongly about their responsibility to protect consumers of health care. Physicians should unite and take notice. Instead of fighting regulation and interest groups, consolidate your energies and work to improve health care. Slowly, but surely, physicians are realizing that the majority will benefit from the information/educational sharing of the Peer Review Organization (PRO) rather than by punitive measures.

Despite this opinion, physicians are not widely participating in the PRO review process, review structure or review research. Concerns are that the program is too expensive. The overall administrative costs of the Medicare insurance system are generally lower than the private insurance sector. Paradoxically, physicians often complain that the PRO does not pay reviewers enough to make it worth their time driving to the PRO office to perform reviews. Perhaps it's more financially gratifying to sit as an expert witness and utilize the tort system, which fuels the health care cost increases that we are trying to control. Consider this statement by James S. Todd MD, executive vice president of the American Medical Association, which appeared in the February 1991 issue of *Physician's Management*: "replace legal due process with professional due process . . . we should be judged

Continued on page 303



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Science and Education

ODH works to stem measles outbreak among Amish

Outbreaks of German measles continues to plague Amish communities throughout the state. Last year, 131 cases of rubella were reported — all but two were located in Amish communities. This year, the figure is closer to 150 cases, all, so far, among the Amish.

The Amish are especially susceptible to large-scale outbreaks of infection because they traditionally have large families and travel frequently among other Amish communities for activities. Last year's rubella outbreak in Medina County, for example, was traced primarily to four barn-raising.

Inoculation clinics were opened this spring to stem outbreaks in Geauga and Trumbull counties. Officials at the Ohio Department of Health believed that the Old Order Amish, who populate these counties, would be more likely to accept inoculations than the more conservative Amish communities, which object to inoculations on religious grounds.

Although the Amish religion doesn't expressly forbid vaccinations, some conservative church districts may discourage them, and, as a rule, Amish rates of vaccination for rubella and other preventable disease are low—probably less than 50%. **OSMA**



Focus on rural health

In January, *OHIO Medicine* painted a picture of rural health in Ohio. Now, June 17-19, the Department of Health and Human Services will be spotlighting rural health on a slightly larger scale as it hosts its first-ever regional conference on rural health care.

The "Region V Health Care Conference: Problems, Strategies and Services" will be held at the Paper Valley Hotel and Conference Center in Appleton, Wisconsin, and will bring together health professionals in the Region V states — Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin — to discuss ways to improve rural health care. Issues to be reviewed include prenatal and obstetrical services, improving primary care, health issues facing rural elderly and minority

populations and HIV-AIDS. Successful examples of projects that are addressing these issues will be shared, with a focus on the development and financing of public/private sector cooperative projects.

Registration fee is \$40. For more information, contact Dave DuPre, Health Care Financing Administration, (312) 353-2322. **OSMA**

Science and Education



Grief and teenagers

Three researchers at Ohio State University Hospitals who have been studying children's reactions to the death of a parent are now studying how such deaths affect teenagers.

Elizabeth Weller, MD, director of the Division of Child and Adolescent Psychiatry and a professor of psychiatry and pediatrics; Ronald Weller, MD, professor of psychiatry; and Mary Fristad, assistant professor of psychiatry and psychology, have received a five-year, \$1.3 million grant from the National Institute of Mental Health to work with children aged 13 to 16. They are also in the third year of a five-year NIMH grant to study how the death of a parent affects children up to age 12.

"We were asking questions of young children, and they were

Toward healthier schools

The Ohio Department of Education is teaming, once again, with the Ohio Department of Health to present the second annual comprehensive school health conference, aimed at improving the health of staff and students in Ohio schools.

The conference, "Health and Learning — A Powerful Partnership," will be held June 18-21 at Salt Fork State Park,

Cambridge, Ohio. General sessions on staff wellness, comprehensive health education and personal wellness will be given, in addition to programs that focus on School Health Services and School Health Instruction. For more information, contact Vickie J. Tollive, ODE, (614) 466-2211 or Morris Stamm, ODH, (614) 644-7854. **OSMA**

telling us how their older brothers and sisters were feeling," says Dr. Elizabeth Weller. "That led us to apply for this other grant."

In this new study, the trio will seek to determine if losing a parent as a teenager has any

bearing on the survivor's depression in later years. They will begin studying the teenagers immediately upon the death of a parent, and work with that person periodically through the years. **OSMA**



Science and Education



New emergency medicine residency approved

A new emergency medicine residency program has been approved at MetroHealth Medical Center in Cleveland and will begin training its first six residents next month.

The program, one of only 75 in the country, is expected to help

alleviate a predicted shortage of emergency physicians over the next 20 years. The residents will divide their time between trauma areas, including burn and other intensive care units, and the emergency room, where the majority of time will be spent. The program will take three years to complete. Anyone interested in obtaining more information about the program should contact the MetroHealth Medical Center. **OSMA**

OSU studies benefits of surgical procedure on partial blockages

Carotid endarterectomies may be an effective technique for reducing the threat of strokes in patients with a major blockage of the carotid artery, but what if there is only a partial blockage? Is the procedure as beneficial?

That's the question Andrew Slivka, MD, Columbus, a neurologist, is attempting to answer through studies at Ohio State University Hospitals. Dr. Slivka is studying patients who are at risk for stroke to see if the surgical technique has any advantage beyond standard medication therapy.

So far, the benefits of using the procedure on patients with moderate arterial blockage (30%-69%) has yet to be proven. **OSMA**

Ulcer drug works on cheetahs

De-Nol, a drug that a Cincinnati-based company is developing to heal ulcers, has been used successfully to treat six cheetahs at the Columbus Zoo. The cheetahs had been suffering from a severe form of bacterial gastritis, but De-Nol, used in conjunction with antibiotics, greatly reduced incidences of vomiting and other symptoms in the cats.

Researchers say that the new drug will be a breakthrough for the chronic treatment of gastritis in

humans once it is released. They believe De-Nol has the potential to heal an ulcer and keep it healed, doing away with years of maintenance therapy.

Although the drug is still waiting for clearance from the U.S. Food and Drug Administration, the agency permitted the use of De-Nol for the cheetahs under a "compassionate use" exemption. The animals became ill late last summer and didn't respond to conventional treatment. **OSMA**

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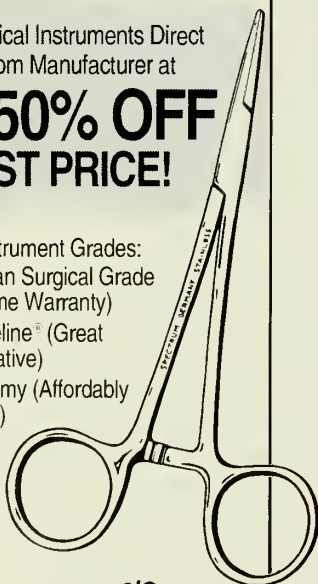
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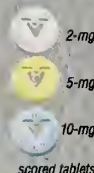
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OHIO Medicine

JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

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COVER STORY

This issue of *OHIO Medicine* provides extensive coverage of the 1991 OSMA Annual Meeting, which was held May 17-19 in Columbus. Find out how the House of Delegates voted on many of the resolutions with AIDS, peer review, IMGs state licensing and the suntanning issue. Hear from incoming OSMA President Joseph Sudimack, Jr., MD, and his plans for the association's future. And, parting words from John A. Devany, MD, immediate past president. Stories begin on Page 330.

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Observations from Annual Meeting '91

The new format for Annual Meeting '91 was generally well received.

The first challenge to the revised program was the early start on

Sunday morning. This resulted in a motion to change the starting time to 10:00 a.m., but the motion was defeated, and the House was called to order at 9:00 a.m.

Changing the OMPAC lunch to an

OMPAC dinner improved the efficiency of the resolution committees executive sessions, as well. For a change, there was no disruption in deliberations. The success of the OMPAC dinner, without any time restraints, was obvious. Vern Riffe again demonstrated his natural talent as a politician and why he continues in his role as Speaker of the Ohio

House of Representatives.

Adjournment of the House of Delegates Sunday afternoon had to be a record. This allowed the delegates to return home and spend some quality time with their families. In addition, Council was not required to stay overnight, since Council business was also concluded the same day.

This format was a trial balloon in an attempt to save costs and to conserve our members' valuable time. Please register your positive or negative comments about the changes in the Annual Meeting format with your district councilor.

I would also like to reacquaint you with the term *paradigms*. This refers to your original patterns, your mold or your model. It is by these standards that you judge change.

I hope your paradigms are flexible, since I intend to call some unorthodox plays in these unorthodox times.

Please communicate your concerns and feel free to offer advice and counsel. Together, we can fill the half-full glass, which the optimist sees to the brim! **OSMA**

**By Joseph
Sudimack, Jr., MD
President of
the OSMA**



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Letters to the Editor

OHIO Medicine's new direction

Editor's note: *This letter is a response to the Letter to the Editor from Robert White, MD, which appeared in our May issue. The response was inadvertently omitted from our June issue, so we are printing it in this month's column, along with our apologies to OHIO Medicine Chair Richard Reiling, MD, its author, for the delay.*

Dear Dr. White:

We are in receipt of your letter in regard to the editorial changes that we felt necessary to make in *OHIO Medicine*. As a leader in your field and also actively involved in medical publishing, your comments and concerns are appreciated.

As a committee we were faced with the challenge to encourage readership and slash the budget nearly 50%. Armed with a recent readership survey and a rapidly shrinking source of advertising dollars, we decided to make a few trial changes.

For many years we welcomed scientific articles for publication, but recently found that the bulk of articles just did not reach a significant portion of our readership. In addition, many articles had already either been published or were refused by multiple journals. And then to have our readers tell us that this was the least important segment of *OHIO Medicine*, we decided to eliminate this section at least for the time being.

We will keep your comments and those of others supporting this type of publishing in mind. After a trial of the new directions we



may well return to the use of scientific articles.

Sincerely,

Richard B. Reiling, MD

Chair, *OHIO Medicine* Advisory Comm.

Re: Health Access America

To the Editor:

The premise that medical care, along with food and shelter, is a *right* went out with the exodus from the Garden of Eden. Genesis 3:19, "By the sweat of your face, you shall eat bread." It is through charity, mercy or practicality that these things are supplied. They are not rights.

Perhaps *subsidized* low-cost basic insurance of the 80/20 variety, with high deductible, should be mandatory. There are many deserving but struggling young people who would benefit, as would hospitals. I think a job,

even minimal wages, should be a requisite.

It behooves hospitals to stabilize costs and prices by stopping excessive building and cooperating, rather than competing, in the use of MRI, etc.

Also, nursing homes are full of old people on Medicaid, whose families should be either caring for them in their homes or paying their way.

George J. Watkins, MD
Milford

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AN ANSWER FOR THE IMPATIENT PATIENT

Note:

In the "Letters To The Editor" of *Medical Economics* for December 24, 1990, an Edward H.

By William B.
Rogers, MD



Vick of New York City wrote a long tirade condemning all doctors and their office scheduling. He had had to wait an hour for an office appointment, so he accused us all of greed.

He suggested we feel our time is more important than the patient's time, and that patients are supposed to feel grateful to be seen at all. He said we're in business and should thus learn to treat patients the way good

customers should be treated.

Medical Economics never saw fit to print an answer to his complaints, so I would like to do so now.

In *Medical Economics* of December 24, 1990, an Edward H. Vick of New York City displayed an ego-inflating tirade of semantics condemning doctors and their office scheduling. I would like to answer his complaints.

I say to Mr. Vick: No, unlike what you accuse us doctors of, we do not feel like God, that our patients are inferior, or that their time is less important than ours. We do not overfill our schedules as a routine or for greed. I am behind schedule almost every day because I am doing my best to see and treat all who think it is needed. I am overbooked trying to help people like you, Mr. Vick, who are calling on me for help!

Now I admit that I was an hour behind schedule today, even though I never overbook unless I feel a patient has a truly urgent problem. Furthermore, I keep a half hour free each afternoon to allow for emergencies or catch-up,

From Our Editors

and I usually do my telephone and paperwork during my lunch hour.

So why was I late? Well, this morning, while on my hospital rounds, I had a call from another hospital about a newly born baby who was having labored breathing. Even though I was due at my office in a half hour for appointments, I went and saw the newborn and initiated treatment.

During the day two of my appointments were for children to be seen for colds and coughs; in both cases the mother brought in a second child without telling us before. In one, a fever of 103° had started just that morning. In the other, the child had a thick yellow-green runny nose and had the family up all night coughing.

Would you have me tell these mothers that my schedule was full and I could not see the second child? I cannot let myself do that, so I got further behind schedule as I examined and prescribed for them.

At 4 P.M. another mother called that her daughter had just fallen and was bleeding from a cut eyebrow. Since I have been the only doctor who has cared for her since birth, the mother wanted me to check the cut and see if I thought stitches were needed. So I told her how to apply a pressure bandage to stop the bleeding and come to my office. The mother asked me to treat the cut if I could, so I took the time to put in five stitches while my appointments waited.

So I was over an hour behind schedule by 5 P.M. and that was not an unusual day! If it is not extra, unannounced patients brought in, we continually have the mothers who schedule a child for one problem but then wants to

“We doctors try to understand your medical concerns and be there to help you when you feel it is needed.”

talk about another problem or two in addition.

Then there are the problems that unexpectedly arise by phone, where there is an ankle badly sprained and could there be a fracture, the sudden onset of crying with an earache, the vomiting that won't stop, etc., etc.

And I haven't even mentioned the phone calls where I must interrupt my appointments for the insurance company that wants more details about why the hospitalized boy with pneumonia and pleural effusion can't go home yet, the laboratory calling about the jaundice level of a newborn, the Children's Service Board calling about a child with suspected abuse, or the phone calls about the child who ate some of grandmother's high blood pressure pills, or fell on his head and now has a big lump, or the one-month old who won't take a feeding and has been crying for eight hours.

And did you ever stop to think that when I am behind schedule as I've described, my office help is an hour or more late in leaving, my wife must keep my dinner warm an hour longer than usual, and

that I am an hour late in seeing my family, going to a social engagement, or attending a medical meeting? Neither my office help, my family nor I like that!

I agree that your doctor should have explained her lateness to you and apologized, but I admit that sometimes I have been so harassed by phone calls and extra patients that I have forgotten the social niceties, too.

We doctors try to understand your medical concerns and be there to help you when you feel it is needed. Please try to remember that there were over 30 other people whom I saw and over 120 who telephoned and felt their problem was just as important, if not more important, than yours, and I had to make that decision. I always trust that I selected the patients to be seen who truly needed it most, and that the ones I only advised or put off were ones who were still well served by my decision.

P.S. Mr. Vick, are you, by chance, an attorney? **OSMA**

*William B. Rogers, MD, is a member of the **OHIO Medicine Advisory Committee.***

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The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIONS AND USAGE: Zantac® is indicated in:

1. Short-term treatment of active duodenal ulcer. Most patients heal within four weeks.
2. Maintenance therapy for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of pathological hypersecretory conditions (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of active, benign gastric ulcer. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of gastroesophageal reflux disease (GERD). Symptomatic relief commonly occurs within one or two weeks after starting therapy and is maintained throughout a six-week course of therapy.

In active duodenal ulcer, active, benign gastric ulcer, hypersecretory states, and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy. 2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although recommended doses of Zantac do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Pregnancy: Teratogenic Effects: Pregnancy Category B: Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: Headache, sometimes severe, seems to be related to Zantac® administration. Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and, rarely, pancreatitis have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, atrioventricular block, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid intravenously for seven days, and in 4 of 24 subjects receiving 50 mg qid intravenously for five days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia have been reported.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling.)

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30° C (59° and 86° F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 ml in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25° C (39° and 77° F). Dispense in light, tight-resistant containers as defined in the USP/NF.

September 1990

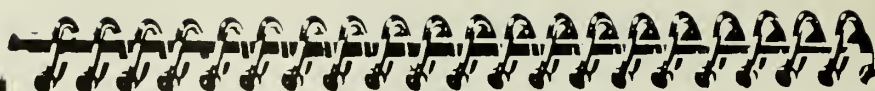
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Clinical Clips

One-third

Number of 1990 medical students who have been stuck with needles

8%

Percentage of exposures from patients with AIDS virus

6%

Percentage of exposure from hepatitis carriers

26%

Percentage of exposure from those with high risk for AIDS

27

Number of health-care workers who acquired AIDS from work

25

Number of cases of Reye's Syndrome in 1989

10 out of 25

Number of patients who died in 1989

6

Number of children under age of five who died

92%

Percentage of kidney recipients alive one year after receiving cadaver kidney

97%

Percentage of survival for recipients who receive kidney from living donor

26,000

Number of students in grades 7 thru 12 who have used steroids

90%

Percentage of youths who have had at least one sex partner in the last year

54%

Percentage who had four or more sex partners

11%

Percentage who traded sex for money or drugs

Sources on Page 320

Association News

A new role for maternal and neonatal health committee

When the OSMA's House of Delegates formed the Committee on Maternal and Neonatal Health in 1954, women were dying in childbirth. They were dying from hemorrhaging, infection and toxemia, and they were dying in shockingly large numbers. In one year alone, 1935, Columbus recorded 4,812 live births with 59 maternal deaths — a rate of 12.1 maternal deaths per 1,000 live births.

Anthony Ruppensburg, Jr., MD, was appointed to chair the committee that year, a position the Columbus obstetrician-gynecologist would hold for the next 30 years. The committee's charge at that time was to study every maternal death in Ohio.

"We hoped that by studying the cause of death of a woman today, we could prevent another woman dying tomorrow from the same cause," said Dr. Ruppensburg in an article about his work with the committee, published in the October 1982 issue of the *Ohio State Medical Journal*.

Every December, the committee released its report to the membership. During the first 10-year study, 1955-1964, 2,266,744 live births were reported in Ohio, and 795 maternal deaths — a ratio of 3.5 deaths per 10,000 live births. The next 10 years, 1965-1974, 1,824,740 live births were reported with 433 maternal deaths — an improving ratio of 2.37 per 10,000 live births. In December 1982, the last year the Ohio Maternal Mortality Study was published in the *Journal*, 488,820 live births were reported during 1977, 1978 and 1979, with 38 maternal deaths on record for



those three years. The maternal mortality rate was 0.9 per 10,000 live births (though that number was deemed "unreliable" by the committee since 21 cases lacked the information necessary to make a determination of cause of death).

Obviously, mortality rates were improving, but the committee noted (with an exclamation point) in its 1982 report that six of the 38 deaths were teenagers.

Times were changing, and they continue to change. This past spring, Craig Anderson, MD, Columbus, the new chairperson of OSMA's Committee on Maternal and Neonatal Health, met with members of its executive committee to determine whether or not the committee needed to redefine its function. New issues, problems and concerns have risen in this field since the days when maternal mortality ranked in large numbers, and the committee wanted a chance to evolve into a group that more closely fit the current maternal-neonatal health climate.

The Sunday meeting that spring day lasted nearly four hours, but at last the committee established a

firm sense of what it is and where it is going. What follows are some of the key points that emerged from that meeting:

- The committee decided its primary function is to serve as consultants for the OSMA in matters concerning maternal and newborn health. The committee should investigate issues referred to it by the executive board, and by members of the committee and make recommendations to the OSMA.

- Four subcommittees were formed to investigate some of the most current issues:

1. Access to Prenatal Care — George Pettit, MD and Patrick Macedonia, MD

2. Drug-Exposed Infants — Craig W. Anderson, MD and James Henry, MD

3. Neonatal and Infant Mortality — Kurt Wegner, MD

4. Obstetrical Anesthesia — Michael Draznik, MD

- The committee discussed the possibility of expanding its interaction with other key medical groups (for example, ACOG and the Ohio Department of Health). They believe that closer interaction

Association News

with these groups would strengthen common causes and attempts to improve and correct recognized problems.

- The committee will educate OSMA members about important issues by disseminating information to them and other liaison groups.

- The committee has decided to broaden its legislative role, and work closely with the OSMA legislative staff to accomplish its goals.

The executive committee will continue to meet quarterly to further redefine its roles and to measure its success. If you would like further information about the committee, or would like to serve as a member, please contact: Herbert Gillen, Executive Director, OSMA, 1500 Lake Shore Dr., Columbus, OH 43204-3824. *OHIO Medicine* will keep you posted on this committee's evolution, and its broadening, more contemporary role. Watch further issues for new developments. **OSMA**

County execs schedule meeting

Executives from each of the county medical societies, along with members of the OSMA staff, will head for King's Island in Cincinnati later this month, July 23 and 24, for a chance to meet and discuss common problems facing both physicians and organized medicine.

Robert E. McAfee, MD, vice chair of the American Medical Association Board of Trustees, will serve as keynote speaker and Paul A. Markowski, the AMA's Field

Representative, Office of County/State Relations, will also be on the agenda.

Doug Evans, Associate Director of the Department of Communications, will give county executives tips on working with the media, then, in his new, dual role as Coordinator of Membership Analysis, Evans will also explain the new direction OSMA membership will take in its effort to recruit new members and retain present members.

A representative from the OSMA Legislation Department will be on hand to update the legislative scene.

Plenty of time will also be allotted for county medical society execs to share thoughts on programs that have or have not worked in their communities. **OSMA**

Animal research education material available

In an attempt to help physicians respond to the news media's extensive coverage of the animal research issue, the AMA has prepared an excellent information packet on the use of animals in biomedical research, which the OSMA is making available to its members.

Included in the packet are:

- a brochure that states that, during the 20th century, most advances in medical science have directly or indirectly involved the use of animals in laboratory studies
- key facts on the animal rights controversy
- background materials
- a sample letter to the editor
- a speech for lay audiences

- a reference list and
- reprints of the two *JAMA* articles dealing with animal research.

The OSMA's Department of Communications also has a complete list of physicians willing to participate in debates or media interviews about the use of animal research.

The idea for the information packets was raised in 1989 by the OSMA House of Delegates. Supporters of Substitute Resolution 55-89 pointed out that recent actions of activist groups had made biomedical research more difficult. It is hoped that interested physicians will use the packets to educate the public about the benefits of using animals in research.

If you would like a copy of this packet, please contact the OSMA Department of Communications at (800) 766-OSMA. **OSMA**

PICO's year-end review

In 1990, the Physicians Insurance Company of Ohio:

- increased its reserves for prior accident years by approximately \$2.5 million on a discounted basis;
- intensified efforts in the area of risk management — not only by implementing seminars and workshops to help physicians better understand the issues involved in malpractice prevention, but by offering premium credits to those who attend;
- established two new departments: client services and new business to better serve its enrollees;
- appointed Thomas W.

Association News

Morgan, MD, Gallipolis, as new medical director and "peer advocate" for physicians;

- initiated physician advisory boards composed of physicians, county medical society staff, malpractice defense attorneys, independent agents and staff to discuss trends and developments in malpractice, focusing specifically on the physician's perspective.

If all of this is news to you, you probably haven't received a copy of PICO's 1990 Annual Report, which was released this spring. Those who would like a copy should contact: Physicians Insurance Company of Ohio, Bates Drive, P.O. Box 281, Pickerington, Ohio 43147-0281. **OSMA**



*Hart and Jean Page
1941*

Hart, Jean Page celebrate their 50th

Hart F. Page, OSMA's executive director emeritus, and his wife, Jean, celebrated their 50th wedding anniversary last month with an open house, held in Columbus. Scores of friends from medicine and other fields came from around

the state to offer congratulations.

Page served as executive director of the association from 1965 to 1985, and had been with the association for 20 years prior to that. In addition to his emeritus title, he also serves as the OSMA's historian and his article, "Dr. Herbert Morris Platter — The Last Statesman," was featured in the February issue of *OHIO Medicine*. Page divides his retirement time between homes in Worthington, Ohio and Sarasota, Florida. **OSMA**

To the doctor's defense

Although today's media seem ever eager for news on the latest medical breakthrough, they're not always as fair and accurate in gathering these stories as they could be.

That's why, last year, the OSMA House of Delegates adopted Resolution 27-90, which called for physicians to collect negative stories about the profession and send them to both their county medical society and the OSMA. The resolution then asked the AMA and the OSMA to "develop and strengthen a central clearinghouse to formulate replies to such articles."

OSMA's Department of Communications has become that clearinghouse, and, in fact, it collects its own medical news stories to evaluate.

"We monitor all of the major newspapers in the state and employ a clipping service to handle the smaller newspapers," says Carol Wright Mullinax, Director of the Communications Department.

When a negative story comes in, either through the department's own sources or through a physician, the Communications Department determines if a response is needed. If it is, the department writes a response, usually in the form of a letter to the editor, on behalf of the OSMA president, county medical societies or individual physicians.

Most of the letters generated recently have dealt with such hot media topics as animal rights, health-care costs and physicians' incomes.

So, the next time an article in your local newspaper sets *your* blood boiling, contact the OSMA's Department of Communications. There *are* times when the pen can be mightier than the scalpel. **OSMA**

OSMA salutes Ohio's outstanding team physicians

Outstanding Team Physician Awards will be presented for the 17th consecutive year by members of the Joint Advisory Committee on Sports Medicine of the Ohio State Medical Association, Ohio High School Athletic Association, and Ohio Athletic Trainers Association.

The awards are presented each year during the annual Ohio High School Football Coaches Association Hall of Fame Banquet. This year, that event will be held Thursday, July 11 at the Four Winds Restaurant in Canton.

Those to be honored include: Thomas D. Swan, MD, Cambridge; Lawrence A. Dils,

Association News

MD, Granville; and Bernard B. Bruns, MD, Cincinnati.

For more than 20 years, Dr. Swan's dedication to the athletic programs at Cambridge City Schools has been a guiding light, writes David E. McMillen, retired administrative assistant and athletic trainer at Cambridge City Schools, in a letter recommending Dr. Swan for the honor.

James C. Spisak, principal at Park Elementary School in Cambridge, adds, "He administered physical examinations for all athletes in our entire school district free of charge, and he served as team doctor for all of our contests and tournaments. His service to these youngsters is a very small part of his professional life within this community where he has practiced for many years."

Dr. Dils also exemplifies the finest qualities of service and professionalism to the student athletes in the school system. According to James E. McCord, superintendent of Granville schools, Dr. Dils has brought honor and pride to team physicians throughout the state.

Dale S. Googins, associate professor and head athletic trainer at Denison University, adds that Dr. Dils has generously provided medical coverage two weeks each summer for the Licking County All-Star Football Games since its inception in 1981. Dr. Dils has been involved as an educator in the community on the subject of sports medicine and has been a regular lecturer at the Ohio Coaches Sports Medicine Clinics held at Denison.

The third recipient, Dr. Bruns, has served as team physician for 20 years for LaSalle High School. The pediatrician has participated in many aspects of the school's athletic department.



"His support and dedication to safety in high school sports, along with his enthusiasm and ability to work well with young people are a few of the reasons he's worthy of this award," says Daniel T. Flynn, athletic director at LaSalle High School.

"All of these physicians are great contributors to their communities, and they are recognized by county medical societies, district councilors, coaches, school officials, civic officials and parents within each physician's community," says Robert Clinger, OSMA Director of the Department of Medical Society and Member Relations.

Clinger explains that prior to 1975, when the initial program was conceived by Richard F. Slager, MD, nothing on this level had been done to recognize these dedicated physicians who give a great deal of volunteer hours to high school athletic programs. Since its inception, 112 Outstanding Team Physician awards have been presented. Congratulations to this year's recipients who join the ranks of outstanding team physicians. **OSMA**



Writing Contest Winner

Herb Gillen, OSMA Executive Director, congratulates Melissa Brokaw, a third year medical student from Northeastern Ohio Universities College of Medicine, winner of this year's Medical Student Writing Contest. Melissa's article, "A Biopsychosocial Profile of the Geriatric Population Who Frequently Visit the Emergency Department," can be found on page 347.

Joyce E. Penn

A LOOK AT AUXILIARY'S NEW PRESIDENT

Editor's note: *Each year, OSMA members are provided with background information on the candidates for the office of OSMA President-Elect. This year, in our Annual Meeting Section, we re-introduce you to Dr. Joseph Sudimack. The following is an*



introduction to OSMA Auxiliary President Joyce E. Penn. In the ensuing months of her term as President, she will write an Auxiliary page.

Joyce E. Penn is a lifelong resident of Columbus, who received a Bachelor of Science degree from Ohio State University's College of Nursing. Following graduation, she enrolled in the master's program in nursing education for another year.

While a student, she met her

husband, Dr. Gerald M. Penn, where both were employed in the laboratory at University Hospital. Married in 1965, Joyce joined the resident's wives group at OSU and began a long-term involvement with organized medicine.

Her early employment included working as a staff nurse on the Clinical Research Unit at University Hospital and a nursing instructor at Mount Carmel Hospital's School of Nursing. Dr. Penn's fellowship in immunology took them to New York City, where Joyce was employed weekends at a local hospital as an evening supervisor. While Dr. Penn served two years in the United States Navy at Bethesda Naval Hospital, Joyce enjoyed caring for their two young sons.

In 1972, Dr. Penn returned to Columbus Children's Hospital, for 10 years. He is currently Director of Pathology at Grant Medical Center in Columbus. Joyce joined the Ohio State Medical Association Auxiliary in 1973 through the Auxiliary to the Academy of Medicine of Columbus and Franklin County. She quickly became active in all aspects of the auxiliary and served as President, President-Elect, Treasurer, Corresponding Secretary, Newsletter Editor, and AMA-ERF Chairperson of the county organization.

Auxiliary Page

At the state level, she has served as President-Elect, Second Vice President, Legislation Chairperson, Treasurer and Liaison to the American Federation of Aging Research. She has also participated and chaired numerous committees on both the local and state levels.

In 1979, she returned to Ohio State, enrolling in business and accounting courses during the year. Although they provided useful training for several auxiliary positions she has held, her avocation in investing for their children's educations and Dr. Penn's pension plan motivated her. She spends most of her free time pursuing this interest and playing duplicate bridge.

She is a member of the Women's Service Board of Grant Medical Center and the Ohio State University Hospitals Service Board. She is past president of Twig 166 of Children's Hospital and a member of Delta Delta Delta Alumnae.

The Penns' two sons, Brad, 23, and Josh, 20, are a recent college graduate and an out-of-state college student.

Looking ahead to her year as President, Joyce says: "I will emphasize the value of investing in auxiliary membership as I visit the 35 auxiliaries organized in Ohio counties. I believe that tomorrow's technology and expert information systems may revolutionize the delivery of health care and be central to medicine's future. Physicians should remain free to act as patient advocates rather than agents of the government or other interests. Intrusions into the practice of medicine necessitate that both partners in every medical marriage should work together. Physicians and spouses need to be informed and prepared through

participating in organized medicine."

There seems little doubt that Joyce E. Penn has chosen to

become informed and involved — and will continue to expend her energy, dedication and leadership in the year ahead. **OSMA**

OSMA Auxiliary Officers 1991-1992

President
Joyce Penn
President-Elect
Sara Rich
Vice-President
Barbara Lach
Vice-President
Valerie Vollmer

Vice-President
Evan Valassiades
Secretary
Vicky Borders
Treasurer
Dolly Handel
Immediate Past President
Sue Massie



Sources for Clinical Clips

Incidences of needle sticks.....*Columbus Dispatch*
Feb. 5, 1991
Decline of Reye's Syndrome*Cincinnati Enquirer*
Feb. 8, 1991
Transplant survival rate*Dayton Daily News*
Jan. 28, 1991
Steroid use*Toledo Blade*
Sept. 21, 1990
Teens and AIDS.....*Cleveland Plain Dealer*

Legislation

Ohio's new living will legislation

After 15 years in Ohio's General Assembly, the living will issue suddenly began to take on new life last year for several reasons:

- The landmark decision handed down by the United States Supreme Court in the *Cruzan v. Director, Missouri Dept. of Health* case sent a message to state legislatures that states may require "clear and convincing evidence" of a patient's desire before life-sustaining treatment can be withheld or withdrawn.

- Over 40 states had already approved such living will legislation.

- The interpretation by the court in *Couture v. Couture* (see Legal section) had suddenly made the two-year-old durable power law ineffective in certain situations.

As an extra incentive, the federal government has also tacked a piece of legislation, the patient self-determination act, onto OBRA '90. This provision, which will take effect December 1 this year, requires all Medicare and Medicaid health-care facilities to advise patients of their rights under state law to make advance directives on the issue of withdrawing life support.

Background

With these incentives in place, then, the time had come for living will legislation, and who better to draft such a bill than the OSMA and the Ohio State Bar Association?

So, this past fall, members of the OSBA's health-care law committee sat down with Cynthia Snyder, JD, Associate Director of OSMA's Department of Legislation, and William Todd, JD, of the law firm Porter, Wright, Morris and Arthur, OSMA's outside legal counsel, and put

The OSMA's Statement on Senate Bill 1

(Delivered to the Senate Reference and Oversight Committee)

Senate Bill 1 represents a commitment by the Ohio State Medical Association and the Ohio State Bar Association to address a concern voiced daily to us, and we suspect to you as well, by Ohioans seeking to have some measure of control over their medical treatment in the event that they become unable to speak for themselves.

For the past several years, the OSMA has been an active supporter of legislation that would recognize patient autonomy, allow adults to execute living will documents and establish accepted protocols for dealing with terminal, incompetent patients who have not executed living wills or durable powers of attorney for health care. With this bill, we have, for the first time, taken a proactive stance on this issue by joining with the state bar association to draft a proposal that we feel speaks to all of these concerns. We are pleased that Senator Betty D. Montgomery (R-Columbus) and the Ohio Senate share our belief that this is an issue that the General Assembly needs to address. It is our feeling that this bill provides a thoughtful, reasoned approach to a complex and difficult issue. OSMA

together a package that was introduced at the Statehouse as House Bill 70 and Senate Bill 1.

"Historically, this type of legislation moves very slowly and is difficult to pass. That's why we decided to introduce it in both Houses," Snyder explains.

Eventually, the focus centered on Senate Bill 1. (Note: Another piece of legislation introduced on this subject, HB 114, is modeled on a Florida statute that prohibited the withdrawal of nutrition and hydration. This bill essentially does the same, and has received only cursory attention in the Ohio General Assembly.)

Senate Bill 1

There are three sections to Senate Bill 1.

The first section makes some

changes in the durable power law. It changes who can witness durable power documents, as well as who can serve as attorneys-in-fact. It eliminates the durable power's seven-year expiration date, so that the document does not expire unless the person executing it specifically includes an expiration date. It changes the definition of "terminal condition" and "life-sustaining treatment" and adds a definition of "comfort care." Taken together, the changes should preclude another *Couture v. Couture* case from occurring.

"The *Couture* interpretation was so restrictive that durable power ceased to be an effective tool," says Snyder.

Senate Bill 1, however, incorporates the AMA's guidelines on nutrition and hydration

Legislation

withdrawal (which state that withdrawal is medically and ethically appropriate in certain situations) to allow their withholding or withdrawal from a terminal patient.

"Even if we hadn't decided to tackle the living will issue, we would have sought changes in the durable power law that would have addressed the problems created by *Couture*," says Snyder.

The second section of the bill formally authorizes adults to draw up living will documents and physicians to honor these documents if the patient is in a terminal condition or a permanently unconscious state. However, certain requirements must be met before the living will can be implemented. For example, the physician must first consult with a person named in the document or with another family member before withdrawing support.

"That doesn't mean the family has veto power, though," says Snyder. In other words, a family member can't impose his or her will over the wishes of the patient. However, the legislation does establish an appeal process that allows family members to appeal the decision of an attorney-in-fact, if the family member believes the attorney-in-fact's decision is inconsistent with the patient's wishes.

The third section of Senate Bill 1 establishes protocols to be followed for those patients, like Nancy Cruzan, who are terminally ill or in a permanently unconscious state, and who have not documented their wishes regarding the withdrawal of life support.

"Even in states where they are legally recognized, most people don't have living wills," says Snyder. "The highest number I've

heard for people who do is 15%."

This section, then, allows a physician to consult with close relatives who may consent to the withholding of life-support treatment for a terminal patient. In the case of a patient in a permanently unconscious state, the family's consent would have to be ratified by the probate court.

"Not all physicians will be happy with this legislation," says Snyder, explaining that it does set up a few additional procedural requirements for health-care professionals. However, it does codify the existing practice that involves decision-making by family members and contains some safeguards to protect against.

"Those physicians who have been uncomfortable acting in this role in the past because of the uncertainty in Ohio law should feel more comfortable with this legislation," says Snyder, especially since it grants physicians certain immunity for their actions, if they perform them in good faith and follow all established protocols.

The biggest impact the legislation may have on Ohio's physicians, however, may be in the area of patient education.

"Physicians are going to have to explain some of the medical terms, like permanently unconscious state, to their patients because the average patient either won't understand the terms or will be confused by them," says Snyder.

The OSMA is meeting with the Ohio State Bar Association to determine the feasibility of developing patient education materials on this issue. Watch future issues of *OHIO Medicine* for dates when this material will be available. **OSMA**

Certificate of Need law under study

Will Ohio's Certificate of Need law be reinstated or replaced when it expires this November?

That is the question that state legislators serving on the Certificate of Need study committee (see sidebar for a list of members) are currently contemplating. To help them with this task the committee has hired Lewin/ICF, a Washington, DC consulting firm, to analyze the strengths and weaknesses of Ohio's CON program. The final report was presented to the committee late last month.

"The reports evaluate whether or not Ohio's CON program has been an effective way to control health-care costs," says John Van Doorn, Director of OSMA's Department of Legislation.

The reports also explore alternative ways that health-care costs can be controlled. For example, in the second progress report, released to the study committee this past February, other state intervention prototypes, such as data collection and dissemination, licensure, competition and rate setting were discussed.

However, no one appears to expect a decision from the committee anytime soon.

"This is a complex issue," explains Van Doorn. Some critics, for example, have decried a lack of fairness in the system and Van Doorn says some seem to have a perception that "there is a lack of a level playing field."

Yet this is only one aspect of the CON program that is under evaluation.

"With the rapid advancement of medical technology and its subsequent cost, CON is being

Legislation

scrutinized as never before," says Van Doorn.

OHIO Medicine will have additional stories on this subject as the November deadline approaches. Watch for future developments in the fall issues. **OSMA**

The Certificate of Need Study Committee

Grace L. Drake (R-Solon),
Chairperson

Robert W. Ney (R-Barnesville)

Eric D. Fingerhut (D-Cleveland)

Frank Mahnic, Jr. (D-Valley
View)

Paul Jones (D-Ravenna)

Michael A. Fox (R-Hamilton)

(Note: Ex-officio members include Directors of the Department of Aging, the Ohio Department of Health, the Department of Human Services, the Department of Mental Health and the Department of Mental Retardation and Developmental Disabilities.)

Four pilot projects that went awry

The proposal seemed sound: Find some way to help small-business owners provide health-care coverage for their workers, and the state's 1.2 million "working uninsured" would be reduced.

So, in October 1989, four pilot projects were launched in Columbus, Cleveland, Cincinnati/Dayton and Stark County to see whether or not such measures would work. The Health Care Coalition in Stark County, for example, created a multiple-employer trust to provide subsidized coverage to certain small employers. The United Way of Greater Cincinnati offered a special benefit package to employers in a 14-county area who have no employee benefit package. In Cleveland, subsidized health maintenance organization benefits were offered to small businesses, while in Columbus, the Bridge Project used a subsidized HMO program for individuals and families who left welfare roles after finding jobs but who could not afford insurance.

The \$2.5 million projects ended last month, victims of the state budget crunch. Their results, according to a report released this spring by the Ohio Department of Health, are disappointing. Although the projects did increase the availability of insurance, they only lowered the costs 20% below market rates.

"Even lower-cost insurance appears expensive to many small employers and low-income workers," Edward Kilroy, director of the ODH, has said in news reports about the projects.

Meanwhile, proponents of Universal Health Insurance for

Some low-income surprises

Although the four pilot projects, initiated by the state to improve accessibility and affordability of health insurance for low-income workers, failed to produce hoped-for results, some surprises did emerge that could change the way insurers view the working uninsured in the future. Here is an overview of what Columbus' Bridge Project discovered:

- The working poor are not the high health-care users they are traditionally believed to be. In the Columbus study, the group's loss ratio was about 80% (the insurer pays out about \$80 in claims for every \$100 in premiums earned). The generally accepted ratio for health-care insurance is 84%.

- Uninsured workers are, on the average, younger than the insured population. They may, therefore, represent *lower* rather than the higher, risks that are generally believed of this group. **OSMA**

Ohio are quick to latch onto the pilot projects' failure as indication of a need for major reform. Such attempts, they say, are only Band-Aid measures and not adequate solutions to a system in need of major overhaul.

Nevertheless, the state continues to seek a consensus that would unite physicians, insurers, employers and patients in a common solution to the problem of Ohio's working uninsured. Such a consensus, however, is proving as elusive as the Holy Grail. **OSMA**

Legislation

SB 110 should interest all Ohio physicians

Once again, Ohio optometrists are back at the Statehouse, attempting to expand their practice to include diagnosis and treatment of eye disease. Senate Bill 110, sponsored by Sen. Robert W. Ney (R-Barnesville), has been referred to the Senate Health and Human Services Committee.

"This is the second session at which this legislation has been introduced," says Michael Bateson, executive director of the Ohio Ophthalmological Society.

Optometrists, however, have been actively seeking to expand their scope of practice since the 1970s. In 1985, they received from the state Legislature the restricted right to use topical ocular pharmaceutical agents for examination purposes only, but so far lobbying efforts by both the OOS and the Ohio State Medical Association have been successful in preventing any further extension of their practices, a success rate the OOS hopes to retain when SB 110 is heard by the committee.

"Our approach is to point out to legislators that expanding the scope of an optometrist's practice does not reduce health-care costs," says Bateson. "In fact, just the opposite may occur."

Delay in recognizing problems, as well as incorrect treatment can actually increase health-care costs, and, as Bateson points out, it's irrational to think that optometrists would charge less for performing the same procedures as physicians.

As far as the optometrist's second reason to expand practice,

increased accessibility, Bateson says, "we don't believe there is a problem in this area." Even as aging Ohioans create an increased need for eye-care, Bateson believes there are enough ophthalmologists in the state to meet the demand.

If SB 110 meets defeat this session, both Bateson and John Van Doorn, Director of OSMA's Department of Legislation, believe the optometrists will be back.

"They're an aggressive group," says Bateson. Van Doorn agrees, but he is quick to point out that optometrists aren't the only group of allied practitioners at the Statehouse.

"Physicians are being challenged by health-care practitioners of all sorts," he says. Chiropractors, nurses, audiologists, physical therapists, psychologists and social workers are some of the groups seeking a bigger share of the health-care pie.

"You have only to look at the bills which are introduced each session to know that this doesn't stop with the optometrists," adds Bateson. "It cuts across the board." (See sidebar for a list of bills introduced by other allied practitioners.)

"It's in the interest of all physicians to stay on top of these issues, and to speak out against these legislative attempts to practice medicine," says Van Doorn.

For more information on what you can do to help the OOS and OSMA oppose SB 110 or any of the other bills brought by allied practitioner groups, contact the OSMA's Department of Legislation at the OSMA offices in Columbus. **OSMA**

Allied Health Practitioners

HB 69 (Rep. Judy Sheerer, D-Shaker Heights) **Allied Health Care Advisory Commission**

Creates a commission to review legislation to license new allied health-care practitioners and to review these new practitioners' attempts to expand their scopes of practice.

Status: Reported out of Ohio House Health and Retirement Committee; referred to Ohio House Appropriations Committee **OSMA policy:** Active support

HB 119 (Rep. Ray Miller, D-Columbus) **Prohibit**

discrimination against psychologists Prohibits discrimination against psychologists in granting hospital staff privileges or membership, but does not permit psychologists to admit patients to hospital.

Status: Referred to Ohio Senate Health and Human Services Committee

OSMA policy: Active opposition

HB 276 (Rep. Frank Sawyer, D-Mansfield) **Chiropractor**

licensing exam — Provides that the Chiropractor Examining Board does not have to afford a hearing to applicants who fail the license exam.

Status: Referred to Ohio House Health and Retirement Committee

OSMA policy: None

SB 110 (Sen. Robert W. Ney, R-Barnesville) **Optometry** —

Expands the scope of practice of optometry to include use of therapeutic drugs in treating the visual system.

Status: Referred to Ohio Senate Health and Human Services Committee

OSMA policy: Active Opposition

Is durable power working in Ohio?

Is the Durable Power of Attorney for Health Care statute (R.C. 1337.11 et seq.), enacted two years ago by the Ohio Legislature, doing an adequate job of solving the sticky "right to die" dilemma here in Ohio?

Not always, and that has prompted the Legislature to turn, once again, to the issue of living wills. Before taking a look at the various living will proposals now being considered at the Statehouse (see Legislation section), it might be helpful to review the current status of the law, including the durable power statute, as well as a couple of Ohio court cases where the statute and the right to refuse or withdraw treatment have been involved.

The durable power statute

The Durable Power of Attorney for Health Care basically allows one competent adult (the attorney-in-fact) to make health-care decisions for another adult (the principal) if and when the latter becomes incapacitated to the extent that he or she is unable to make these decisions for him or herself. Keep in mind two things, however. The durable power is not limited to life and death decisions. Any health-care decision may be involved. Second, the statute does not allow the attorney-in-fact a totally free rein. There are restrictions. For example:

1. The attorney-in-fact can't refuse or withdraw informed consent to health care necessary to maintain the principal's life unless the principal is in a "terminal" condition. In the statute, "terminal" is defined as "imminent death," however "imminent death" is not itself



defined.

2. The attorney-in-fact can't refuse or withdraw informed consent to health care necessary to provide "comfort care," a term the statute also leaves undefined.

3. The attorney-in-fact is not permitted to make a decision for a principal if the principal is pregnant and the decision would terminate the pregnancy. That is, unless the pregnancy or health care poses a "substantial risk" to the principal, or unless the attending physician and one other physician determine, to a reasonable degree of medical certainty, that the fetus would not be born alive.

4. The attorney-in-fact can't refuse or withdraw informed consent to the provision of artificial nutrition or hydration unless the attending physician and another physician believe it would not provide comfort to the patient; and either death is imminent so the patient is not likely to die from malnutrition or dehydration, or the nutrition or hydration could not be assimilated or would shorten the principal's life.

5. The attorney-in-fact cannot, of course, make decisions contrary

to the expressed wishes of the principal, unless at least one of the following applies: the principal's physical condition has changed so that the health-care benefit has significantly decreased; or the health care is not significantly effective in achieving its purpose.

The statute also has other restrictions:

1. It sets forth specific limitations on who can serve as attorney-in-fact.

2. It sets an expiration date, usually seven years.

3. It requires that durable powers be dated, signed by the principal, witnessed or notarized.

4. It specifies the means for revoking a durable power.

5. It requires a notice describing the effects of the document to appear on any durable power form printed and distributed in Ohio.

Couture v. Couture

So far, there has been only one Ohio court case where the durable power statute has been addressed.

Couture involved the parents of a 29-year-old man who had been in a persistent vegetative state for a few months. The parents disagreed over whether or not their son should continue receiving nutrition and hydration through a feeding tube. The Montgomery County Court of Appeals refused to allow the withdrawal of the feeding tube, based on its interpretation of the public policy inherent in the durable power statute. The court said it wouldn't sanction withdrawal, even if the son had left written rather than oral instruction to do so, because R.C. 1337.11 reflected a public policy opposed to such withdrawal from a patient whose death was not imminent, notwithstanding the patient's wishes or those of his or

Legal

her surrogate.

Since no other Ohio court has spoken on the application of durable power, and since *Couture* was a guardianship case, it's still uncertain how the law will be interpreted in other Ohio courts. However, the results of one earlier Ohio case, *Leach v. Akron General Medical Center*, in which the patient's right to forego life-sustaining treatment was at issue, may provide some clues.

Leach v. Akron General Medical Center

A woman suffering from amotrophic lateral sclerosis was terminally ill and in a persistent vegetative state following a heart attack. Her husband asked that she be removed from the respirator, but the hospital refused and the matter went to trial.

There, the court balanced the patient's right to refuse treatment (based on her right to privacy) against four state interests: 1. Preservation of life; 2. The interests of third parties; 3. the ethical integrity of the medical profession and; 4. The prevention of suicide.

Since the patient's condition was called irreversible by three neurologists who testified at the trial, the court allowed the respirator to be removed. However, it also established certain procedural safeguards, including setting up "clear and convincing evidence" as the standard for proof that a patient wishes to discontinue life support.

Back to the drawing board

It's the *Couture* case, however, that has sent the Ohio Legislature back to the drawing board to re-examine the living will issue.

In a speech before members of the Ohio Continuing Legal

Education Institute, OSMA Managing Director Brent Mulgrew, JD, explains why:

"Viewing the right to die, and specifically to refuse nutrition and hydration from a constitutional perspective, especially after *Cruzan*, necessarily calls the decision in this case into question. The Court of Appeals for Montgomery County has asserted Ohio's statutory durable power announces the public policy against refusal or withdrawal of nutrition and hydration, not only by attorneys-in-fact but by guardians as well. I believe this policy may violate the United States Constitution by depriving a patient of the liberty to refuse further treatment. In addition, since the durable power statute does not honor an incompetent patient's express wishes not to be given artificial food and hydration, the statute itself may fail a constitutional challenge on the same liberty theory.

"In response to this concern, the Ohio General Assembly is currently considering legislation that would expand the durable power of attorney for health care, as well as provide for us the use of living wills in Ohio."

What form this legislation will take remains unclear. However, Mulgrew says it appears any final legislation will eliminate the possible constitutional infirmity of the present durable power statutes.

For more information about the living will legislation, see the Legislation section. If you have questions concerning durable power or either of the court cases presented here, contact the OSMA's Legal Department. Also, don't forget that the Department of Communications offers patient brochures about durable power to OSMA members. You may obtain

copies for your office by contacting the Department of Communications at (800) 766-OSMA. OSMA

Limitations statute clarified on child abuse

The Ohio Supreme Court ruled on May 1, 1991, that the statute of limitations on charges of child abuse does not begin to run until a "responsible adult," under legal duty to report child abuse, is made aware of the crime. Such responsible adults would include counselors, lawyers, nurses, school officials, social workers, and, of course, physicians. (See R.C. 2151.421)

Knowledge by both victims and parents of victims did not trigger the running of the statute of limitations.

The court's unanimous decision reinstates the January 1989 convictions of a Montgomery County man on five counts of rape of a child under the age of 13. The Ohio Court of Appeals (2nd District) ruled that the six-year statute of limitations had expired between the time the crimes were committed, between 1974 and 1979, and reported to the police (in 1987). Those rape convictions had been dismissed by the appeals court. OSMA

Legal

New contraceptive causes controversy

Norplant may be the answer to the birth control issue, however physicians are questioning the legal ramifications in providing Norplant to minors without parental consent.

The law states physicians need parental consent for any kind of non-emergency surgical procedure performed on a minor, according to Katrina English, JD, OSMA staff counsel. Since Norplant is administered by implanting matchstick-sized capsules under the skin in the upper arm under a local anesthetic it is considered a minor surgical procedure, and it appears the physician's hands are tied.

"It really clouds the issue (of parental consent) because it's the first time we have to consider giving birth control to minors that requires a surgical procedure," says English. So far this procedure doesn't seem to be causing any problems for OSMA physicians, according to English, but she attributes this to the fact that the procedure is relatively new and costly.

Whereas private physicians need parental consent before administering Norplant, physicians working with the Planned Parenthood Federation do not. Planned Parenthood argues that teens (15 and older) should be allowed access to contraception without parental consent no matter what the procedure. Under Title X of the Family Planning Act, which provides a third of Planned Parenthood's budget, it states that all services must be confidential and cannot require parental consent, says Carol Reynolds, coordinator of information and development for Central Ohio's



Norplant is administered by implanting matchstick-sized capsules under the skin in the upper arm.

Planned Parenthood.

Hospitals, like private physicians, are likely to insist on consent for Norplant. One for instance, Miami Valley Hospital, plans to require parental consent as a legal precaution before its doctors administer Norplant to teenagers. Why? "It's not just playing it safe," says Lorrie Ellis, director of the hospital's ambulatory perinatal care, "it's the law that we seek the parent's consent before doing a surgical procedure on an unemancipated minor except in emergency."

As of this writing Central Ohio Planned Parenthood did not have Norplant available to patients, primarily because of the cost — \$350 per kit, plus an additional \$150 to \$250 for insertion. The manufacturer has refused to reduce the cost for Planned Parenthood or other health departments.

For those unable to pay the hefty \$500 to \$600 tab, the state of Ohio is seeking Medicaid approval, as California and Texas have done, says Reynolds. As it stands,

Medicaid in Ohio has approved \$350 for the Norplant equipment and \$125 for the insertion fees.

"This still denies the middle class woman any assistance, since health insurance companies refuse to pick up costs related to the procedure," says gynecologist Shirish Shah, MD, Toledo.

The price has not kept Dr. Shah from performing several Norplant insertions, both at Planned Parenthood in Toledo and in his own office, but he predicts the number would be much higher if cost was not a factor. Not only has Dr. Shah performed the procedure numerous times, he has trained physicians in Toledo and around the state. Dr. Shah became skilled in the procedure while in the Dominican Republic, where Norplant has been used for the last 15 years.

Some argue that offering Norplant ought not to be any more controversial than prescribing birth-control pills. These individuals reason they both release chemicals into the body,

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they just do it differently. But, it's that difference — oral vs. surgical — that is causing the controversy.

The appeal Norplant may have in the future worries some health-care experts. "Since this contraceptive is effective for five years, we are worried that no follow-up exams will be necessary until the patient decides to remove the rods or repeat the procedure. Ultimately, this could result in yearly gynecological exams being ignored," Reynolds says. Dr. Shah has similar worries but interjects that this "shifts the responsibility back to the patient." He's observed over the years that by the time some patients (especially teens) get around to visiting him to renew their birth-control prescription they are already pregnant. The question comes down to whether it is better to help avoid pregnancy (or abortion) and disease, or to let these patients risk becoming parents.

Dr. Shah believes the key to making the Norplant procedure successful is to be selective of the patients who receive the procedure and to provide patients with adequate counseling. **OSMA**

Legal dilemmas ahead for HIV-infected physician

To tell or not to tell, that is the dilemma facing health-care professionals infected with the HIV virus.

This spring, the New Jersey Superior Court, in the nation's first court decision on the matter, ruled that a patient's right to be safe from the possibility of

exposure to AIDS during surgery outweighs an HIV-infected surgeon's right to practice.

In Florida, Gov. Lawton Chiles is pushing for the first state law that would require HIV-infected health-care professionals to report their condition to a medical board.

Meanwhile, the Atlanta-based Centers for Disease Control is expected to issue guidelines for HIV-infected health professionals soon.

Until those guidelines have been received and studied, and despite the nationwide climate surrounding this subject, OSMA's Department of Legal Services suggests that Ohio physicians who are HIV positive follow the policy set forward by the American Medical Association. The AMA statement says that physicians who are HIV positive have an *ethical* obligation not to engage in any professional activity that has an identifiable risk of transmission of the infection to the patient. The AMA also states that HIV-infected physicians should either abstain from performing invasive procedures that pose an identifiable risk of transmission, or disclose their seropositive status prior to performing a procedure, and perform only if there is informed consent.

"If more incidents of HIV transmission to patients are discovered, more and more malpractice cases will be brought against HIV-positive providers and more and more health-care facilities will seek to terminate the duties of these providers," says Brent Mulgrew, JD, managing director of the OSMA.

Leckelt v. Hospital District No. 1

In fact, the Fifth Circuit Court of Appeals has already upheld a hospital's decision to discharge a possibly HIV-positive nurse. In

Leckelt v. Board of Commissioners of Hospital District No. 1, the plaintiff was a licensed practical nurse whose roommate was hospitalized for the treatment of AIDS. The hospital encouraged Leckelt to be tested. Leckelt informed the hospital that he had been tested and that he would provide the results to the hospital. The hospital learned that plaintiff tested positive for hepatitis B and had had a history of syphilis.

When Leckelt refused to disclose the results of the HIV test, the hospital terminated his employment. Leckelt sued, asserting claims under Section 504 of the Federal Rehabilitation Act of 1973 and the Louisiana Civil Rights for Handicapped Persons Act.

The Fifth Circuit upheld the hospital's termination, holding that the plaintiff failed to establish that the discharge was due to a handicap. The court found that Leckelt's discharge was based upon a failure to comply with hospital policy and was, therefore, permissible.

"Such restrictions of the providers' ability to engage in their professions will undoubtedly result in many actions under Section 504 of the Federal Rehabilitation Act and state statutes protecting the rights of the handicapped," says Mulgrew. He adds: "At this point, however, it is too early to predict how these cases will turn out, or whether state and federal legislatures will choose to address this particular issue with further legislation." **OSMA**

Editor's note: *New legislation has been introduced which would require physicians to declare their HIV-status. Next month's "Legislation" section will carry a report.*

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Dr. Devany addresses OSMA House

When John A. Devany, MD, was elected OSMA president last year, he promised to serve with heart, with humor and with humility. He kept that promise to the end of his term. In his presidential address, during the opening session of the House of Delegates, he quipped, "As I look back on my term of office, I am reminded of what Golda Meir said to one of her cabinet members: 'Don't bother with the humility, you weren't that great.' "

On a more serious note, Dr. Devany turned to what he considered to be the most important health-care event of the past year — the establishment (by House of Representatives Speaker Vern Riffe) of a special Select Committee on Health Care Reform. "The importance of this committee cannot be overstated," he said. It was created because seven pieces of legislation were pending, which touched on some aspect of health-care cost and access, and the speaker realized that the potential for a donnybrook existed, he explained.

"Probably the most important legislation is House Bill 175," he said, continuing, "As you are no doubt aware, the OSMA opposes this bill, but we have made certain that Chair Barney Quilter and the committee members are aware of the fact that we do not oppose health-care reform in general."

The message Dr. Devany tried to reiterate when he testified at the committee in March and again in his remarks at opening session is that "we (doctors) recognize the problems inherent in our present health-care delivery system, but we also recognize its successes and we



Joseph Sudimack, Jr., MD, newly elected OSMA president, presents pin to John A. Devany, immediate past president.

want to improve what we have."

"If I had one lesson reinforced during this year it was this: Politics is not a spectator sport. It is one-on-one, day-by-day contact that will succeed for us," he said. Dr. Devany couldn't emphasize enough the importance of personal contact in influencing legislators.

Searching for a solution to health-care cost and access cannot go overlooked, according to Dr. Devany. "There is *not* going to be any more money for health care. It is going to be really difficult to hold on to the levels that we have now in the face of even minimal inflation and the continuing influx of people going on Medicare and the long life expectancy of the elderly." Dr. Devany believes it's time to reach out to other groups — business people, manufacturers, other medical associations, insurance companies and review organizations — for help. "We are

trying to separate the wheat from the chaff — and we need help saving the wheat," he said. "The problems we face cannot be solved by any one organization or any one segment of society. It is going to take a national dialogue to address these challenges and to resolve these critical issues. It is going to take discussion and debate among all interested parties," he said.

Looking into the future, Dr. Devany sees reimbursement as the most pressing issue. According to Dr. Devany, by determining what procedures are reimbursed and to what degree third-party payors can not only control costs, but, in reality, can dictate how physicians practice medicine.

He said he has no problem defending the income of the average Ohio physician who also happens to work 60 to 80 hours a week. "Physician fees are already

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severely restricted by Medicare, Medicaid, HMOs and other health-care entities. Mandatory Medicare assignment legislation is a slap in the face for the average Ohio physician," said Devany.

But despite some gloomy prospects, all is not despair. "We have significant ability to affect our future. I hope we have the will. We have abundant talent. We must make our voices heard on local initiatives, on public health problems and with voluntary organizations," Dr. Devany says.

"Medicine is a gift — a trust — and it is we who are responsible for its perfection. Everyone knows the importance of making a living, but all of us worked our behinds off to get here because we wanted to make a difference. Let us be about it." **OSMA**



John A. Devany, MD, immediate past president addresses House of Delegates.

Desert Storm participants honored

A star-studded, red, white and blue slide presentation was an ideal way to kick off the 1991 OSMA Annual Meeting held in Columbus May 17-19 in view of recent world events. The patriotic production, created by the AMA, brought glimpses of America to the silver screen. It seemed only appropriate for John Devany, MD, OSMA president, to follow the tribute to America with an introduction of a resolution commemorating Operation Desert Storm.

The Ohio State Medical Association took the opportunity at its Annual Meeting to officially recognize the contributions of the many physicians who were called to serve their country in Operation Desert Shield and Desert Storm.

The resolution stated that these physicians responded to the call with great patriotism and courage.



In serving their country, they made considerable sacrifices both personally and professionally. These physicians succeeded, under imperfect conditions, to create and maintain a health-care system capable of offering comfort and care to American and allied soldiers.

Members of the House of Delegates offered these physicians a heartfelt thanks for a job well done. **OSMA**

OSMA approves child care provisions

The House of Delegates adopted Amended Resolution 34-91, which called for child care in hospitals. The resolve directed the OSMA to strongly encourage hospitals to establish child care provisions for hospital personnel and staff physicians.

Donavin Baumgartner, MD, supported the resolution and testified in the reference committee that "there's another growing area where people have concern and that's caring for the

elderly." He also pointed this out at the Final Session of the House of Delegates.

Claire Wolfe, MD, added that the resolution should include *all* hospital staff and should be available 24 hours a day.

A second resolve was added to read that the hours and staffing of child care facilities should take the needs of physicians-in-training and medical students into consideration. **OSMA**

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OSMA gets tough on AIDS risks

Ohio physicians made it clear at this year's Annual Meeting that they are no longer willing to expose themselves unknowingly to the risks of HIV infection. They want something done, both by legislators and insurance companies, to protect them from what they perceive to be unnecessary risks. (While the OSMA resolutions don't affect current law regarding AIDS, they do give the association's lobbyists a new game plan when dealing with this issue at the state Legislature.)

"It's a different time now," said Douglas Hess, MD, Fourth District Delegate, speaking before the resolutions committee that heard testimony on the subject. "We know more now. Physicians don't want restrictions on how we order these tests."

"It's time we treated AIDS like every other communicable disease," added Donavin Baumgartner, MD, OSMA past-president and Fifth District Delegate. As an emergency room physician, Dr. Baumgartner said he is continuously at risk of infection, and pointed to a multiple-trauma case that came into the ER recently as an example. "There was blood all over the place, so we repeatedly asked the patient if he had AIDS. Each time the patient said he didn't, but as it turned out, he did have an HIV infection. He had placed a number of people at risk."

Stanley Fox, MD, a Fifth District Delegate who said he had discovered one of the first Ohio AIDS cases in 1981, pointed out that 20 states already have HIV reporting and contact tracing, and added that Ohio needed to join



that group. "The time has come," he said.

The House of Delegates apparently agreed. In its Final Session, three of the resolutions introduced on the subject were adopted and two more were referred to Council for further study. Those adopted this past May include:

- Substitute Resolution 45-91, calling for state legislation that would permit physicians to test patients for HIV infection, just as they test for other communicable disease. The resolution also asked for legislation that would require HIV anonymous test sites to develop a code for identifying and notifying infected individuals who don't return for test results.

- Amended Resolution 46-91 is similar to the previous one. It asks the OSMA to pursue state legislation that would require the medical community to treat HIV infection like other communicable diseases in areas such as testing, reporting, tracking and contact tracing.

Although Amended Resolution 61-91, also adopted by the House, deals with a broader scope of infectious disease, its major concern is with the HIV virus. The resolution seeks legislation that would require hospitals and morgues to put an infectious disease warning tag on all bodies determined to have died of a reportable infectious disease, whether that be tuberculosis, syphilis, serum hepatitis or HIV.

George Lindner, president of the Cleveland Embalmers Society, said in testimony before the committee that few hospitals currently tag infected bodies.

The two resolutions referred to Council for further study both dealt with the financial liability of health-care professionals who become HIV seropositive in the course of their duties. Resolution 50-91 called for OSMA to work with the insurance industry to develop insurance plans for these individuals, while Resolution 52-91 asked for legislation that would expand the benefits under workers' compensation to include AIDS-related complications. Because both issues are complex, they were referred to Council for further study and clarification. *OHIO Medicine* will bring you progress reports on each of these matters as they come under Council's advisement. **OSMA**

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Annual report is framework for future

Attendees at the OSMA Annual Meeting had an opportunity to preview the first ever annual report compiled by OSMA's Communications Department.

According to Carol Mullinax, Director of Communications, instead of using the usual slide show presentation to highlight OSMA's year, staff members decided to pool their talents and create an annual report. In addition to the highlights and activities undertaken by the OSMA in the past 12 months, legislative, reimbursement and legal issues are also represented.

The report compares creating an association to constructing a building. There is a blueprint, for example, which, in an association, translates into a set of rules or bylaws; and the architects — the OSMA leaders — who mold and shape the blueprint until it becomes a smooth and functioning reality. The OSMA members are the builders "producing a structure that can withstand the winds of change and the challenges of time."

Anyone interested in obtaining a copy of the annual report may contact the OSMA Department of Communications at (800) 766-OSMA. OSMA

Four honored with memorial resolutions

The OSMA House passed memorial resolutions in honor of:

Frank H. Mayfield, MD, a Cincinnati resident, born in Garnett, S.C. in 1908, served as president of OSMA in 1959-60. Prior to that, he had served as the association's First District Councilor from 1956-58. He was the recipient in 1980 of the American Medical Association's Distinguished Service Award. During his lifetime he also served as president of the Academy of Medicine in Cincinnati in 1950 and as president of the Society of Neurological Surgeons from 1967-68. He served with the U.S. Army from 1942-45. He died on Jan. 2, 1991.

Edwin H. Artman, MD, born on Aug. 24, 1910 in Portland, Ind., was a long-time resident of Chillicothe. Dr. Artman was a general practitioner with a special interest in anesthesiology. He served with distinction for four years in the U.S. Army Air Force as a flight surgeon. Prior to being named OSMA president in 1960, Dr. Artman served for six years as the OSMA's Tenth District Councilor and as an alternate delegate to the American Medical Association. He was elected as a delegate to the AMA in 1961 and served through 1967. He died on Jan. 4, 1991.

John P. Minton, MD, FACS, an acclaimed surgeon and cancer expert, died on Dec. 1, 1990, at the age of 56. Dr. Minton was active on the faculty and medical staff of The Ohio State

University, with appointments in the Department of Surgery, Department of Microbiology and Zoology, and in the School of Health, Physical Education and Recreation. Dr. Minton was the recipient of many honors and awards for teaching and research, being named recipient of the Ohio State Medical Association's Gold Teaching Award in 1977 and the association's Gold Award for Original Investigation in 1977. In 1991, the Ohio Chapter, American College of Surgeons established the John Peter Minton Cancer Award presented in his honor in conjunction with the chapter's annual resident essay contest.

William H. Havener, MD, a Columbus ophthalmologist who served as chair of the Ohio State University Department of Ophthalmology from 1959 to 1961 and from 1972 to 1989, died on March 7, 1991. Dr. Havener exemplified excellence in teaching ophthalmology from 1950 until his death, and received Teacher of the Year Award from OSU Medical School Class of 1978. Dr. Havener was the recipient of many prestigious awards, including the first Excellence in Ophthalmology Award given by The Ohio Ophthalmological Society in June 1990. Two of his many community interests included Mothers Against Drunk Driving and The Ohio Society to Prevent Blindness. Dr. Havener had a profound interest in his community and an impact on generations of medical students and residents. OSMA

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Auxiliary president reflects on year

"Unique and challenging" were the adjectives Sue Massie used to describe her experience as auxiliary president.

John Devany, MD, now immediate past president of the OSMA, reminded those in attendance at the opening session of the OSMA House of Delegates of Sue Massie's philosophy of life: "If you pass through this world and miss the opportunity to make a contribution to make a difference, you've really missed the boat." Sue Massie never missed the boat.

The auxiliaries have made great strides this year under her leadership. Massie elaborated on some of the auxiliary's events and projects.

"Ohio auxiliaries have developed a strong commitment to promote a positive image for the medical community by letting the public know that we physicians and auxiliaries are striving to make the quality of life better for the citizens of Ohio and this nation," said Massie.

Massie went on to explain that the auxiliaries try to acknowledge physicians' contributions to the aesthetic side of life, and, through a communications workshop held in January, auxiliaries were provided with the necessary tools to get this message across to the media.

"Planning ahead and being prepared is crucial to success," she said, continuing, "with this in mind a leadership training day was held for physicians and auxiliaries in May. We were happy that so many physicians were in attendance." This leadership training day prepares the county leaders for participation in legislative efforts, health projects,



Auxiliary President Sue Massie reflects on her year in office

membership recruitment and raising funds for AMA-ERF.

AMA-ERF is a well-supported effort of the auxiliaries. "This is our legacy to medicine," Massie said.

The auxiliary has also made great strides in becoming legislatively informed and in taking an active part in keeping physician spouses informed as well, said Massie. The Day at the Legislature is a good example of the contribution the auxiliary makes to ensure that health legislation is in the best interests of the people of Ohio. "Legislation is our most powerful avenue for progress," she said.

"One of our most exciting projects by far was working on the *From Hot to Cool* brochure, which dealt with ultraviolet radiation. This state-of-the-art brochure is an effective educational tool," Massie points out. The OSMA Auxiliary House of Delegates passed a resolution, which they will take to

the AMA Auxiliary, regarding the adverse affects of ultraviolet radiation and tanning booths.

The efforts of the auxiliary have brought on many positive changes, however "the problems are not solved. Many challenges remain. We are being manipulated constantly by social problems magnified by cost containment. However, we have choices and voices. We need to be aware and strive to do something about it," Massie said.

"Remember, auxiliaries are your greatest fans and ardent supporters. We must continue to work together for a better future for all." OSMA

Medical schools receive endowments

Medical schools of Ohio will see some positive changes thanks to the efforts of the auxiliary. Sue Massie, OSMA Auxiliary President, and John Devany, MD, OSMA President, presented checks totaling more than \$88,302 on behalf of the auxiliary and the AMA's Educational Research Foundation (AMA-ERF). The schools and their endowments are as follows:

- Case Western Reserve University School of Medicine — \$13,703.97
- The Ohio State University College of Medicine — \$23,666.51
- University of Cincinnati College of Medicine — \$23,554.49
- Medical College of Ohio, Toledo — \$8,821.24
- Wright State University School of Medicine, Dayton — \$8,155.77
- Northeastern Ohio Universities College of Medicine, Rootstown — \$10,400.44

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Stanley J. Lucas, MD new president-elect

Stanley J. Lucas, MD, was elected to the position of President-Elect of the Ohio State Medical Association during the Final Session of the House of Delegates, which met this past May in Columbus.

Prior to being selected for this post, Dr. Lucas had served the OSMA for five years as a Councilor from the First District and as an Alternate Delegate to the American Medical Association. Dr. Lucas has also been a Delegate from Ohio to the AMA since 1987.

In accepting the office, Dr. Lucas said he had been told that "life is a ticket to a wonderful world to live in, and you, as a doctor, have a front-row seat." He said that he would use that front-row seat to work for the improvement of medicine.

Results from other elections, held during the Final Session of the OSMA House of Delegates, are as follows:

- John F. Kroner, MD, was re-elected OSMA Secretary-Treasurer.

- For Councilors from the even-numbered districts:

(all were re-elected)

Second District: Walter A. Reiling, Jr., MD

Fourth District: Su-Pa Kang, MD

Sixth District: Robert C. Reed, MD

Eighth District: Thomas J. Hall, MD

Tenth District: Claire V. Wolfe, MD

Twelfth District: Jack L. Summers, MD

- For Delegates to the AMA to serve terms commencing January 1, 1992 and ending December 31, 1993:

John E. Albers, MD



Stanley J. Lucas, MD, and wife, Judy, receive congratulations on Dr. Lucas' position as president-elect

Donavin A. Baumgartner, Jr., MD

John A. Devany, MD

Edward G. Kilroy, MD

Henry G. Krueger, MD

William J. Marshall, MD

Joseph Sudimack, Jr., MD

Lee J. Vesper, MD

Claire V. Wolfe, MD

- For Alternate Delegate to the American Medical Association to serve terms commencing January 1, 1992, and ending December 31, 1993:

Stephen T. House, MD

Owen E. Johnson, MD

William T. Paul, MD

Ronald L. Price, MD

Victoria Ruff, MD

Jack L. Summers, MD

David Utlak, MD

- For Alternate Delegate to the AMA to serve term commencing May 19, 1991 and ending December 31, 1991: Ronald L. Price, MD.

- For Alternate Delegate to the AMA to serve term commencing January 1, 1991 and ending December 31, 1992: Frederick Suppes, MD.

- Scott Kramarich, Cincinnati, was elected by the OSMA Medical Student Section as an Alternate Delegate for one year, commencing March 10, 1991. OSMA

Annual Meeting 1991

Medicine is still a good profession

With a clear view of the direction the Ohio State Medical Association is taking and with a firm belief that "there is hope for the profession of medicine," Joseph Sudimack, Jr., MD, accepted the presidency of the OSMA at the annual session of the House of Delegates.

Dr. Sudimack alluded to the ample opportunities and challenges that are ahead and remarked: "As I tackle the job of president during the next year I hope to be able to live up to *my* expectations."

Stating that he's an optimist, Dr. Sudimack made it clear that he doesn't intend to turn his back on problems but rather look for the good in everything.

"Yes, I know that much is happening in medicine that is bad. But I contend that there is much that is still good about medicine in this country," Dr. Sudimack says.

For example, he told delegates that "the United States still has the best health-care system in the world — one which in many ways continues to improve." As proof, he pointed to the dramatic turnaround in the nation's infant mortality rate — a 6% decline in the past year — the largest drop in a decade. Today more than 80% of newborns weighing 1.2 to 2.2 pounds survive, bettering by 10% the survival rate of those infants 15 years ago.

Dr. Sudimack also boasted that new technology has made it possible to diagnose and treat patients with pancreatic and colon cancer faster than was possible 20 years ago. And thanks to new technology, most of the 1.5 million Americans suffering heart attacks survive.

"Patients are recognizing our



Dr. Sudimack's family join members in congratulating him

excellence," said Dr. Sudimack. A recent survey conducted by the American Medical Association backs him up. That study showed that 90% of patients think it is important to have a personal physician, and the majority feel that doctors take a genuine interest in their patients; 85% were satisfied with their last visit; 89% feel they have access to a medical specialist when they need one; and 80% feel they have access to the latest medical technology.

In general, Dr. Sudimack believes more and more physicians are sharing his optimism about medicine. Medical schools, for example, are showing a sharp increase in applicants, reversing a 14-year decline.

"As I traveled around the state this year visiting with and listening to OSMA members, I became impressed all over again at how knowledgeable you are, how concerned you are about your

patients and how dedicated you are to the profession," said Dr. Sudimack. He pointed out that Ohio physicians routinely offer free or discounted care to patients who cannot afford care.

"When patient care is threatened, doctors take the leadership role in protecting the rights of patients," said Dr. Sudimack. "OSMA spearheaded efforts this past year to develop the Ohio law that established a durable power of attorney for health care." He added that OSMA, along with the Ohio State Bar Association, were responsible for developing living will legislation. These actions are not only aimed at protecting physicians but also at promoting the good of the patient.

"I'm the type of guy who thinks the glass is half full, *not* half empty. During my term of office I'd like to see the glass overflow," says Dr. Sudimack. To

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do this he'd like to become more involved in issues that impact physician and patient care. "We need to stop focusing on the issues that divide medicine and focus instead on issues that unite us," he said. **OSMA**



Joseph Sudimack, Jr., MD, OSMA President believes medicine is still a good business

New faces at OSMA Council

You can't count Stanley J. Lucas, MD, OSMA's new president-elect, as one of the new faces at OSMA Council this year. After all, as First District Councilor, a post Dr. Lucas held for five years, he is well known to OSMA members. Nor can you look for any new visages among the Councilors themselves. All six who were up for election this year (Councilors from the even-numbered districts) were re-elected to their positions.

So who is new to Council this year?

Joyce Penn, for one. She is the new president of the OSMA Auxiliary and replaces that group's immediate past president, Sue Massie, at the Council table.

Another new face this year is Stephen House, MD. The OSMA's Hospital Medical Staff Section voted Dr. House its new chair at its Annual Meeting this past May. He replaces Edmund W. Jones (now with the AMA's HMSS), who had served as OSMA-HMSS chair since the section's inception six years ago. Also new this year are Thomas M. Andrews, MD, the new president of the Resident Section, and Richard Villareal, Jr., the new leader of the Medical Student Section. Villeareal joins his father, Richard Villareal, MD, Ninth District Councilor, in what proves to be the first father-son team to sit at OSMA Council. **OSMA**

Kroner re-elected

John F. Kroner, MD, was re-elected OSMA's Secretary-Treasurer during the Final Session of the House of Delegates, which met this past May in Columbus. Dr. Kroner is a Board-certified obstetrician-gynecologist, in private practice in Athens. Dr. Kroner was appointed OSMA's Secretary-Treasurer during the 1990 Annual Meeting. In addition, he has served the association as Eighth District Councilor, and as delegate to the OSMA for 17 years. He has also served as a member of numerous OSMA committees.



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Ohio schools to learn dangers of suntanning

In May, *OHIO Medicine* brought you the story of Lou Barich, MD, and his fight to pass the first tanning parlor ordinance in the country.

Now, the OSMA has decided to take medicine's crusade against unsafe tanning one step further.

At its Annual Meeting this past May in Columbus, the OSMA House of Delegates voted to adopt Amended Resolution 60-91, which calls for the OSMA to work with the Ohio State Board of Education to bring information about the hazards of ultraviolet radiation into Ohio schools.

"We educate students about the dangers of smoking, hazardous wastes and other dangers, so we should educate them about this," said Jerry Kimmelman, MD Fourth District Delegate, in testimony before the committee. "There is always talk about the cost issue. Well, if we can reduce the number of skin cancer cases through education, then we will have reduced costs."

Stanley Fox, MD a Fifth District Delegate, added that: "We must get across to children that there is no such thing as a safe tan. Sunning yourself is like exposing yourself to a nuclear reactor. The question is, how much radiation do you want and the answer is, not very much."

Dr. Fox was one of several physicians, most of whom were dermatologists, who pointed out that more and more cases of skin cancer are showing up in younger and younger patients. One physician testified that one of his patients was an 18-year-old girl.

"Out of 700,000 students, 100,000 will be diagnosed with skin cancer," says Edmund Casey,



Lou Barich, MD, in deep thought at OSMA Annual Meeting

MD, First District Delegate. "And almost 80% of exposure to the sun comes before the age of 20."

William Kitzmiller, MD, OSMA's First District Councilor, says he makes a diagnosis of malignant melanoma "maybe once a month," and he urged all physicians to look carefully at a

patient's back for evidence there of skin cancer.

A similar resolution was taken to the AMA House last month by the Ohio delegation. *OHIO Medicine* will carry a story on AMA action on this matter in a future issue. **OSMA.**

OSMA considers HMSS resolutions

The following Hospital Medical Staff Section resolutions were considered at OSMA's Annual Meeting; held this past May in Columbus. Actions on each resolution are printed after its title.

- 73-91 *Physician Fee Determination by Contractual Arrangement Between Third-Party Payors and Hospitals* — adopted and placed on consent calendar.

- 74-91 *Recognition of OSMA-HMSS Founders* — amended/adopted

- 75-91 *Economic Credentialing* — adopted and placed on consent calendar

- 76-91 *OSMA Legal Counseling Services for Hospital Medical Staff Bylaws Concerns* — referred to Council

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Council to consider medical economics committee

The problem of the uninsured and underinsured is no longer just a medical problem; it's a societal problem.

"Probably no issue being discussed before this house of medicine is more germane to the core of medical practices in the Akron/Summit County area than the uninsured," says Jack L. Summers, MD, of the Twelfth District, referring to Resolution 16-91. This resolution, calling for an Ohio Health Care Commission to propose short- and long-range solutions to the problems of health-care economics, was one of over 70 resolutions to come before the OSMA House of Delegates at its Annual Meeting, held this past May in Columbus. "We've watched our rubber companies disappear from our community. Our friends to the east in Youngstown have watched the furnaces of their plants go out; and our friends in Cleveland have watched their steel mills close. The result is a vast amount of people who no longer have medical insurance."

"We (physicians) frequently find ourselves in the position of objecting to someone else's plan or following plateaus that don't really have substance," says Dr. Summers.

He thinks physicians know what's best for the patients of Ohio and that it's time to marshal their resources in the best possible manner. "It's time to sit down as physicians and decide what minimal health care should be in Ohio, whether that means changing Health Access America into legislative language; whether it means developing our own basic health-care package to every citizen



Donavin Baumgarter, MD, OSMA past president

of Ohio; or some other situation. It's time we proactively attack this problem. We should have a position to offer rather than one to defend."

While the majority of the committee members at the OSMA Annual Meeting supported the intent of Resolution 16-91, they also felt that the issue is complex and needs to be examined in relation to the information generated from other groups examining the health-care access situation.

Victoria Ruff, MD, testified at the reference committee that "this isn't something we should do by ourselves. We don't need to reinvent the wheel. We should demand support and expect some input from other agencies working on this issue."

One group already working on this issue, for example, is the Opportunity for Change committee designed by Edward Kilroy, MD,

the new director of the Ohio Department of Health. Walter Reiling, MD, Second District Councilor and one of the physicians involved in Opportunity for Change, explained that the committee includes physicians, nurses, insurance carriers and business people. (As this issue went to press, results from the report were still pending. Action on this issue will be reported in subsequent issues of *OHIO Medicine*.) "The report may not be what medicine wants to see, but it seems to me until this report comes out perhaps adopting this resolution would be premature," says Dr. Reiling, adding, "Much of what Dr. Summers is asking for is being discussed. I think we should see what comes from this report before we start another endeavor."

Another member of the Opportunity for Change committee, Robert Davies, MD, believes one thing that can be done is to combine basic medical services. "We should emphasize services, not benefits. Benefits are inpatient, outpatient, surgical, post traumatic, rehabilitative, but we never explain what services are. What's intermediate? What's high style? It's like saying we'll cover three meals a day, that's your benefit, but you don't know if the service is a McDonald's hamburger or the Maisonette. To continue with the hamburger analogy. . . we should define services as so many grams of protein per pound per day rather than get your beefsteak wherever you want."

Health-care costs in America will reach \$700 billion next year, that's \$3,000 for every man, woman and child, according to Dr. Davies. "The commission sorely needs to look into this issue," he says.

Donavin Baumgarter, MD,
continued on next page

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OSMA members voice frustration with peer review

Physician frustration with peer review became evident this past May as eight resolutions, all focusing on peer review issues, came before OSMA's House of Delegates at its Annual Meeting, held this year in Columbus.

Resolution 27-91 dealt with the PRO quality inquiry letter and who should receive a copy of it. The resolution called on PROs to provide a copy of the initial letter to hospitals where the named physician is on staff.

William Hamelberg, MD, Tenth District Delegate and author of the resolution, explained in testimony before the committee that the quality assurance department often has no idea how many physicians have seen and acted on an inquiry



William Hamelberg, MD, Tenth District Delegate, speaks out at Final Session of the House

letter sent to them. Often, he said, they haven't, then the quality assurance chair suddenly receives a "confirmed letter," which follows an initial inquiry letter, and is forced to follow up on it, adding additional work to the quality assurance committee's already heavy workload.

"This resolution puts the cost in both dollars and time (of such follow-up) back onto the PRO where it belongs," said Dr. Hamelberg in testimony before the House.

Gerald Penn, MD, a Tenth District Delegate, agreed that quality assurance committees need help orchestrating how a response goes back to PRO.

However, Claire Wolfe, MD, OSMA's Tenth District Councilor and a member of the Board of Directors of Peer Review Systems, Inc., was hesitant to see quality inquiry letters reaching hospitals at the same time they reached physicians.

"Hospitals could begin to use these inquiry letters against the doctors and begin to establish a form of economic credentialing," she said.

Stephen Richardson, MD, senior vice president of medical affairs at Peer Review Systems, Inc. said, however, that such an action would be against PRO regulations.

Stephen House, MD, the new chair of the OSMA's Hospital Medical Staff Section, moved, on the floor of the House, that the resolution be referred to Council, "so we can see what the AMA is doing on this issue," with a report back to the House in '92. The resolution was referred. (Note: As of April 1, 1991, the Ohio PRO began sending affected hospitals a separate copy of a physician's quality inquiry letter.)

However, three resolutions, all of

Economics Committee ... continued

OSMA past president, supported the idea of allowing Council to make the decision at the appropriate time. "The fiscal part of the resolution bothers me — \$150,000 per year. We can't afford this kind of money at the present time," he says. The resolution was referred to Council. **OSMA**



Robert Davies, MD

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which dealt with peer review, were adopted at the House's Final Session.

- Amended Resolution 29-91 resolved that the PRO not intentionally interfere or inappropriately influence appointments to quality assurance and/or utilization review committees made by hospital medical staff or administration.

- Resolution 31-91 resolved that the OSMA and the AMA petition HCFA to preclude application of a law, rule or regulation prior to its effective date.

- Resolution 32-91 resolved that the OSMA and the AMA petition HCFA to annually require the state PRO to publish and forward to quality assurance hospitals under its jurisdiction the names of physician advisers and their specialties. The Ohio delegation took this resolution to the AMA House of Delegates for its consideration at its 1991 Annual Meeting last month. A future issue of *OHIO Medicine* will provide details of the AMA's action on this item. **OSMA**

IMGs question state licensing requirements

International medical graduates, concerned about upcoming legislation that would increase the amount of graduate medical education required of IMGs from 24 to 36 months, introduced a resolution to the 1991 OSMA House of Delegates that:

- called on OSMA to support the 24-month requirement for IMGs who are licensed by another state and who are applying for reciprocity in Ohio and

- directed the OSMA to support the requirement that IMGs may take the FLEX exam after completing one year of postgraduate education.

At committee hearings, most of those who testified on this bill spoke in favor of adoption, and pointed out that the additional training called for in the new legislation seemed to be discriminatory.

"I don't know why this group should be singled out for 36 months of training," said Thomas Hall, MD, Eighth District Councilor.

Daniel Santos, MD, First District Delegate, added that, if the legislation passed, Ohio would be taking a step backward.

"I realize there is such a thing as diploma mills," he said, but he believes that the system already in place is sufficient at weeding out unqualified medical graduates.

Thomas Gretter, MD, Fifth District Delegate, and Robert Heidt, MD, both members of the Ohio State Medical Board, testified, however, that the Board currently has no criteria for rating medical schools not located in this country, and that can make licensing IMGs a difficult

procedure.

"Frankly, we have a problem evaluating that quality of the training," said Dr. Heidt.

"Without putting in a timeframe, we thought there might be a perception that we were letting people in through the back door," Dr. Gretter added in testimony before the full House.

Although the committee assigned to this resolution recommended that the House adopt its amended version, there was still dissatisfaction with the resolution's final form. Several international medical graduates for example, contested the addition of a phrase that called for completion of five years "competent practice" in the state in which the IMG was licensed before reciprocity was granted with 24 months of training. Because no general consensus could be reached, and because the House decided that the Ohio State Medical Board should be consulted for further clarification, the matter was referred to Council for further study.

Next month, *OHIO Medicine* will take a broader look at international medical graduates and the problems they face through an article prepared by OSMA Fourth District Councilor, Su-Pa Kang, MD. Dr. Kang is a member of the IMG Advisory Committee of the American Medical Association, and he will write of the committee's work to date. **OSMA**

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OSMA acts to halt practice of medicine by non-physicians

It's not enough that optometrists are trying to "practice medicine" (see Legislation section). Now there are other limited practitioners who are hoping to do the same.

The OSMA, however, has every intention of stopping these groups from gaining any more ground, and this past May, the OSMA House of Delegates adopted two resolutions that may help to do just that.

Amended Resolution 36-91 stemmed from an incident where a company, which performed pre-admission evaluation and post-admission monitoring onsite at hospitals, sent psychologists to interview patients there.

Donavin Baumgartner, MD, OSMA past president and Fifth District Delegate, expressed concern at the practice, and told the committee hearing testimony on this resolution that "this is not a matter of money, it's a matter of quality of care." He also testified that allowing this type of action might set a dangerous precedent. "Next, you'll have a non-physician reviewing whether or not a patient needs to see an internist," Dr. Baumgartner warned.

Stephen House, MD, the new chair of the OSMA's Hospital Medical Staff Section, also expressed some concern about the message set forth by this practice. "Gatekeeping is obviously a part of managed care, but it should be done by physicians," he said. "We need to seek legislative change in this area."

However, a new perspective on the matter was raised by H. William Porterfield, MD, an

alternate delegate from the Tenth District and chief executive officer of the Columbus-based Physicians Health Plan. Dr. Porterfield said: "In the real world, we have a shortage of physicians who are willing to get into those areas like alcoholism and mental health. That's what the real problem is."

No matter how the problem is defined, however, the OSMA House elected to adopt Amended Resolution 36-91. The resolution calls for the OSMA to urge the AMA to take appropriate action to challenge programs in which the need for hospitalization is determined by non-physicians.

With that matter resolved, the House proceeded to Resolution 64-91, which dealt with the matter of make-up artists who advertise the availability of permanent cosmetic make-up through the use of intradermal tattooing, a service these "artists" conduct in malls and hotels. Since intradermal tattooing punctures the skin surface and since the use of needles introduced into the skin can transmit both infection and disease, the procedure could be construed (and has been by some plastic surgeons) as the practice of medicine.

The Ohio State Medical Board, which has the authority to investigate matters where the unlicensed practice of medicine occurs, was reluctant to launch investigations into this area, since it wasn't sure it had the power to regulate this particular practice.

"This would be a problem issue for the board if you were to count the tattoo parlors in with this," said Robert Heidt, MD, one of the Ohio State Medical Board's newest members, in testimony before the committee.

However, Stanley Fox, MD, Fifth District Delegate, expressed

concern about the practice. "We shouldn't allow amateurs to mess around with this procedure," he said.

In its recommendation, the committee placed this resolution on the consent calendar for rejection, but the resolution was extracted from the calendar in the House, and testimony, similar to that given before the committee the day before, was given. The House finally voted to adopt the resolution. Its resolve calls for the OSMA to urge the Ohio State Medical Board to stipulate that injection of cosmetic make-up constitutes the practice of medicine. **OSMA**



Stephen House, MD, the new chair of the OSMA's Hospital Medical Staff Section, testifies at reference committee.

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Construction of incinerator prompts new environmental/health concerns

Apparently, it's not enough for Ohio to generate its own toxic wastes. It's also the dumping ground for other countries as well.

"Ohio is the largest importer of hazardous wastes," said Teri Scorgen, RN, who testified at this year's Annual Meeting on a resolution that called for the OSMA to take a closer look at this environmental problem.

Amended Resolution 59-91 was introduced by the Sixth District when it learned that a commercial hazardous waste incinerator plant would be built by Waste Technologies Industries on the banks of the Ohio River in East Liverpool.

According to the resolution's authors, if this incinerator is permitted to operate, the plant will process at least 176,000 tons per year of hazardous wastes, which will be stored on site in 134 storage tanks with a capacity of nearly three million gallons of liquid, pumpable wastes.

As if this danger wasn't enough, the authors pointed out, as did Scorgen in her testimony before the committee, that interstate transportation of hazardous wastes by truck and rail adds to the risks.

"This makes it more than a local issue," Scorgen told the committee.

The resolution urged the OSMA to express its opposition to the appropriate authorities regarding the construction and eventual operation of the hazardous waste incineration plant. It also asked the OSMA to establish or assign one of its committees to study the

problems of hazardous waste so that "concerned members may have access to the most recent state and federal guidelines," and be able to advise community leaders on how to address the growing public concern about hazardous wastes.

Charles Hickey, MD, an alternate delegate from the Tenth District, echoed that concern when he testified before the committee on this resolution.

"I'm one of the biggest toxic waste generators in Franklin County — at least I hope I am," he joked. Then, he added: "But I'm concerned about the toxic

waste I generate, and I think all physicians are. We need to address this issue soon."

The House voted to adopt Amended Resolution 59-91 at its Final Session. **OSMA**



OMPAC honors award winners

OMPAC chair Jerry Kimmelman, MD, left and OSMA Auxilian Dee Talmage (Mrs. Lance) became recipients of the Distinguished Service Award, presented annually to recognize those who demonstrate active involvement in the medical community. William Kose, MD (center), vice chair of OMPAC, presented the awards.

Science and Education

Medicine show goes hi-tech

Back in September, *OHIO Medicine* told you about two medical students at Ohio State University's College of Medicine who had put together a traveling medicine show. Their dramatic black and white photographs took viewers on a fantastic voyage through the human body. The exhibit, which is now housed in the Cleveland Museum of Health and Education, featured six 8-foot-high panels dealing with preventive medicine, specifically: teenage pregnancy, AIDS, heart disease, smoking and cancer.

Now, the project has gone video.

The 30- to 60-minute slide show is approved for viewing by all audiences, according to Seth Guterman, one of the creators. "Our motto is: 'We'll present to any group, anytime, anywhere as long as they have a white wall and electricity.'"

Guterman and his partner, Jonathan Liss, enlisted the help of 80 medical/nursing students who volunteer their time to take the health message to grade school students, business organizations, religious groups, sororities and fraternities.

A statewide campaign is to be launched this fall. The students hope by then the slide show will be available on videotape. All of this has been made possible by the Department of Preventive Medicine at OSU and the Ohio Cancer Information Service.

"Our goal was to give the public a way to prevent a health problem, to give them control of their own health," Guterman says. Liss interjects, "If the public can understand how things happen and their susceptibility to hazardous behavior, they may be willing to



Jonathan Liss (left) and Seth Guterman design medical slide show

make lifestyle changes."

In conjunction with the slide show, the Cancer Information Service is conducting a study to see how much health information is retained by the audiences. A pre-test is followed by a questionnaire immediately following the presentation. A third test is given six months later.

Anyone interested in obtaining the slide show may contact Joanne Hichik at 293-4600 in Columbus or (800) 4-CANCER. **OSMA**

Cincy researchers study Chernobyl victims

On April 26, 1986, a nuclear plant in the Soviet Union town of Chernobyl exploded. Now, a team of Cincinnati researchers, including Gordon Livingston, an associate professor in the University of Cincinnati Medical Center's Department of Environmental Health, is studying the long-term health effects of the accident.

"We think that we're unique in Cincinnati in that we have the Soviet immigrants right here with us for the study," says Livingston.

Most of those participating are from the areas around Kiev, Gomel and Mozyr. They came to Cincinnati through the Jewish Family Service's Soviet Resettlement Program. Since June 1988, about 300 Soviet citizens

Science & Education

have moved to the Queen City area.

Livingston and his co-workers have taken blood samples and full-body radiation readings from about 70 Soviet citizens who lived within 150 miles of the Chernobyl plant. Preliminary findings show the subjects have physical and biological evidence of exposure. Cesium 137, one of the most damaging and longest-lived radioactive elements released by the explosion, has been detected. So have chromosomal mutations in white blood cells.

Five years, however, is too short a time to observe what the effects of radiation will be.

"It's clear that radiation is a carcinogen," says Livingston. However, he adds: "We don't have any idea what it will mean for their long-term health."

Only a handful of teams in the U.S. are conducting similar research, which could have applications for victims of radioactive accidents, workers in the nuclear industry and residents who live near nuclear sites. Findings from the study will be presented within the next year.

Meanwhile, officials with the Institute of Radiation Medicine in Minsk, capital of Byelorussia, say 1.5 million Soviet citizens have been tested for radiation exposure, and more than 700,000 are part of a long-term monitoring program.

OSMA

PHYSICIAN OPPORTUNITY

A Natural Selection

St. Luke's Healthcare Association – a progressive, 418-bed multifacility healthcare system located in Saginaw, Michigan – currently has private practice and hospital career opportunities for physicians in selected areas of specialization.

The Association provides a complete range of specialty care units, including adult and pediatric intensive care, coronary care and emergency care. We operate Michigan's only combined medical/behavioral health center, treating adults, adolescents and children. We recently opened The Family Birth Center™ – a progressive, new, single-room obstetrics unit. And we co-operate in an active residency program affiliated with

Michigan State University's College of Human Medicine.

St. Luke's Healthcare Association is a diverse and growing organization, anxious to meet with physicians interested in pursuing a career marked by a strong administration/physician working relationship and a team approach to patient care.

If you're such a physician, St. Luke's Healthcare Association and Saginaw, Michigan, are natural selec-

tions. Contact us today for additional information.

**Call or write Jan Gould,
Physician Recruiter:
St. Luke's Hospital
700 Cooper Ave.
Saginaw, MI 48602
1-800-633-3546.**



Obituaries

MORTON E. BLOCK, MD,
Pompano Beach, FL; New York
Medical College, New York, NY,
1934; age 83; died May 5, 1991;
member OSMA and AMA.

RAYMOND E. CLARKE, MD,
Cincinnati; Meharry Medical
College, Nashville, TN, 1920; age
93; died April 4, 1991; member
OSMA and AMA.

ALVIS R. HAMBRICK, MD, St.
Augustine, FL; Ohio State
University College of Medicine,
1948; age 70; died April 26, 1991;
member OSMA and AMA.

CHARLES A. HUBAY, MD,
Chagrin Falls; Case Western

Reserve University School of
Medicine, 1943; age 73; died April
20, 1991; member OSMA.

DAVID F. KOTLAREK, MD,
Westerville; Medical College of
Ohio at Toledo, 1987; age 33; died
March 28, 1991.

ROBERT B. RARDIN, MD,
Oxford; University of Rochester
School of Medicine Dentistry,
Rochester, NY, 1949; age 72; died
May 10, 1991; member OSMA and
AMA.

F. EUGENE ROACH, MD,
Cleveland; Harvard Medical
School, Boston, MA, 1936; age 81;
died April 27, 1991; member

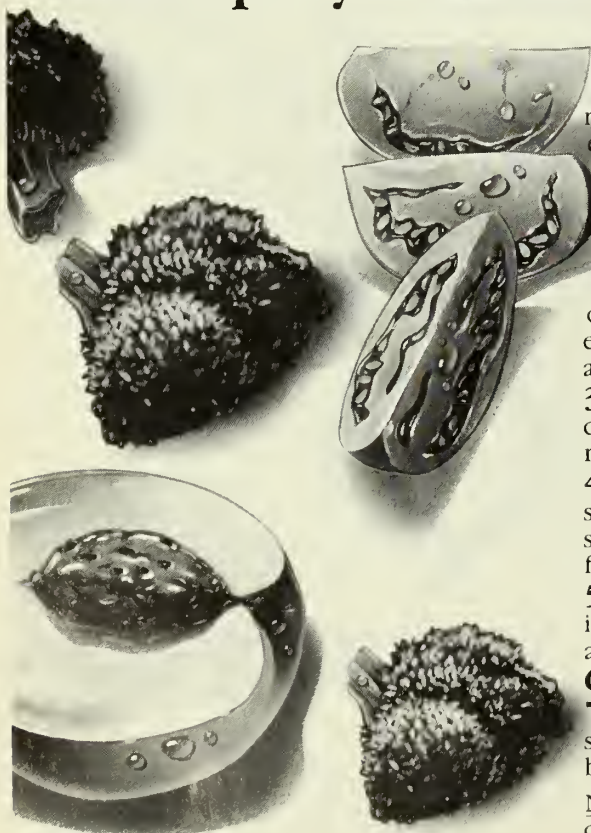
OSMA and AMA.

NELSON W. RYAN, MD,
Cincinnati; University of
Cincinnati College of Medicine,
1933; age 83; died May 2, 1991;
member OSMA and AMA.

ROBERT J. SATING, MD,
Lakewood; St. Louis University
School of Medicine, St. Louis,
MO, 1937; age 77; died April 15,
1991; member OSMA and AMA.

MAURICE SHIMEK, DO, Salem;
University/Osteopathic Medicine &
Sciences, Des Moines, IA, 1977;
age 47; died March 1991; member
OSMA and AMA.

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Writing Contest Winner

A Biopsychosocial Profile of the Geriatric Population Who Frequently Visit the Emergency Department

Principle Investigators:

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Northeastern Ohio Universities College of Medicine

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Psychiatry Resident

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Department of Psychiatry and Behavioral Sciences, Akron General Medical Center — (216) 384-6511
Emergency Medicine Department, Akron General Medical Center

Abstract

Over the last two decades the emergency department has become the primary source of health care for a large segment of the population. While this practice is discouraged by ED staff and primary care providers, it is an unfortunate reality. Recent literature has examined the use of the ED from many different angles. Areas investigated include various demographics (age, sex, race, etc.), method of payment, presenting complaint, and availability of primary care. Repeated inappropriate use of ED services by individuals (the so called "frequent fliers") has also attracted attention. The interest in this sub-population of patients is presumably due to the prevalence as well as the excessive costs of this behavior. In the present study a retrospective chart review was used to establish the biopsychosocial profiles of geriatric patients identified as being frequently seen in the emergency department for non-urgent conditions. Even though only 11% of the US population is age 65 or older, the elderly in America consume 30% of the health care resources, and in the next 20 years that figure is expected to climb to 50%(1). Demographics, ED presentation, diagnosis, and treatment as

well as past medical history were collected. The objectives of the study were to identify these elderly frequent fliers and determine what could be the reasons behind the inappropriate use of emergency department resources by these patients.

The average age of the sample was 74. The marital status of the sample was as follows: 42.4% widowed, 27.2% married, 15% divorced, and 18.5% single. Over half (52.6%) of those patients were brought to the ED by ambulance. The most common presenting complaint was chest pain (20.8%), followed by somatic complaints (18.9%), GI (16.1%), dyspnea (13.7%), and change in mental status (12.8%). The most prevalent ED diagnosis was psychiatric (18.4%) in nature. The other diagnoses were somatic (16.6%), GI (11.8%), and pulmonary (10.9%). 88.5% of the sample reported to have a primary care physician. However, 45% of the ED visits occurred between 9AM and 5PM at a time when a physician should have been available. The admission rate for this sample was 21.9%, which is half what has been found in the "normal" elderly, as reported by McDonald and Abrahams.¹

Writing Contest Winner

Introduction

The establishment of emergency medicine as an independent discipline and a unique science over the last 20 years has made it the primary health care resource for a large portion of the population. This kind of medical practice, beside being excessively costly, lacks the continuity of care necessary to adequately manage patients with chronic conditions. The effective utilization of emergency departments has recently been the focus of many extensive studies, many with the purpose of enhancing a triage system that would be able to make an acceptable discrimination between urgent cases and non-urgent conditions. The areas that have been investigated include the location of the emergency department (urban vs community), the population served by the hospital with regard to age, sex, marital status, race, income, as well as availability of primary care and the method of payment. The nature of the pathology that would precipitate use of the emergency services more than other pathology (i.e. psychiatric illness, alcohol abuse, homelessness, drug abuse, etc.) has also been discussed.

The objective of this study was to examine the charts of patients identified as frequenting the ED for non-urgent conditions and to investigate and highlight a comprehensive biopsychosocial profile of those patients over the age 65 or older. Due to the changing age structure of the American population, more attention is being focused on the use of health care resources by the geriatric population. Currently, 11% of the population is over the age of 65. In the next 20 years the geriatric population is expected to consume 50% of the health care resources.² In addition, the fastest growing portion of the U.S. population is over the age of 85.²

Methods

The sample studied was from the emergency department of a 540-bed community hospital with university association. The hospital is located in the downtown area of a mid-sized (500,000) midwestern city.³ The ED had 49,754 visits in 1989 and of those 32,233 were treated and released.

The ED staff (attendings, residents, nurses and social workers) of all three shifts were asked to identify patients over the age of 18 who were judged to frequent the ED for non-urgent purposes. The ED staff was able to identify 860 frequent fliers dating back to (and including) 1986. Of those, 62 (7.2%) were age 65 or older. Forty-one of these elderly patients had at least one visit to the ED in 1989.

These 41 elderly patients comprised our sample. Their charts were carefully examined to collect data to help understand the biological, psychological and social characteristics of the geriatric frequent flier. Standard demographic information (age, sex, race, etc.), form of payment, primary care physician, number of ED visits in 1989, presenting complaint, ED diagnosis and treatments rendered were coded for each subject. The charts were also reviewed for past medical diagnoses, ongoing treatment and any past psychological diagnosis. All of the information was obtained through a retrospective chart review. No concurrent or prospective data was obtained.

Results

Overall the geriatric frequent fliers identified averaged six visits a year. The average age of the sample was 74. Males comprised 40% of the total and females 60%. This compares to Jacoby's findings regarding the sex of geriatric repeat ED users (33% and 67% respectively).³ 27.2% of the sample was black and 63.6% was white. The population composition of the area in which the hospital is located has a population distribution of 10.9% black and 89% white.³ Marital status of our sample was as follows: 42.4% widowed, 27.2% married, 15% divorced, and 18.5% single. Half of the sample of frequent fliers had private supplemental insurance which is somewhat lower than the 70% found in the overall ED geriatric population.⁵

In our geriatric frequent fliers, 57.5% of the visits arrived to the ED by ambulance. This is congruent with Ettinger⁶ and Powers⁸ who noted 54.6% and 46%, respectively, of the elderly patients arrived by ambulance and 88.5% of the sample reported to have a primary care physician.

**TABLE I:
Demographic Results**

Mean Age: 74	
Marital Status:	widowed 42.4%
	married 27.2%
	single 18.5%
	divorced 15.0%
Male: 40.0%	Female: 60.0%
Black: 27.2%	White: 63.6%
Transportation:	ambulance
	52.6%
	private car
	42.9%
	public 4.0%
Time of visit:	9AM to
	5PM: 45%
	5PM to
	12AM: 36%
	12AM to
	9AM: 19%

Table 1 is a summary of the demographic results.

The most common presenting complaint was chest pain (20.8%), followed by somatic complaints (18.9%), GI (16.1%), dyspnea (13.7%), and change in mental status (12.8%). The most prevalent ED diagnosis was psychiatric (18.4%) in nature. The other diagnoses were somatic (16.6%), GI (11.8%), and pulmonary (10.9%). The admission rate of our sample was only 21.9%.

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TABLE II: Chief Complaint and Diagnosis by Visit

Chief Complaint		Diagnosis	
chest pain	20.8%	psychiatric	18.4%
somatic	18.9%	somatic	16.6%
GI	16.1%	other	13.3%
dyspnea	13.7%	GI	11.8%
change in mental status		pulmonary	10.9%
other		musculoskeletal chest pain	9.9%
psychiatric		MI/angina	8.0%
GU		abnormal BP	5.2%
		medication	4.2%

Discussion

The American College of Emergency Physicians has established guidelines of what is considered an emergency.⁹ They stated that "In emergency medicine it is the patient who prospectively determines what constitutes an 'emergency.' The patient defines the reason, time, and point of entry into the system, regardless of ability to pay, age, or the ultimate nature of the illness/injury."¹⁰ But the lack of definite criteria that will include or exclude a frequent flier makes that determination a subjective judgment done by the ER staff.

Jacoby compared various demographic factors between patients who repeatedly use the ED and those who do not. She found that 63% of the visits by the repeaters were considered non-urgent vs 40% by non-repeaters.¹¹ Buesching, et. al. found that 10.8% of all visits to ED were inappropriate.¹² The concept of different definitions of "an emergency" was examined by Wolcott, who found that the inappropriate use of ED resources was often met by hostility (overtly or covertly) by the ED staff.¹³ Other authors such as Dickhudt, et.al., looked at an economic profile in ED utilization that suggested 61% of the inappropriate or marginally appropriate visits were welfare patients.¹⁴

Ettinger, et.al. compared the use of the ED by elderly and non-elderly patients and found that the elderly patients were more likely to have a medical presenting complaint and more likely to be admitted to the hospital (51.1% vs 14.4%).⁶ Baum and Rubenstein also focused on the geriatric population's use of the ED and found that a high percentage (95%) identified a primary care physician and the elderly patients were more likely to arrive by ambulance (35%).⁷

Although 88.5% of the patients in this study reported to have a primary physician, 45% of the ED visits occurred during "office hours" (9AM to 5PM). This may have been due to any of the following: 1) the patient did not call their physician first, 2) the patient could not be seen by their physician that day, 3) the patient does not understand when it is appropriate to use the ED 4) the patient's physician referred him or her to the ED for acute care or 5) the patient perceives that he or she is receiving "better" care (faster, larger staff, etc.) at the ED. In

some instances the patients did have urgent conditions.

Of the elderly patients in our sample 72.8% were either single, divorced or widowed. Nationally 41% of the population over the age of 65 fall into this category.⁴ While it cannot be assumed that the patients are totally without a support system, it does suggest that this area warrants further investigation.

The frequent use of the ambulance (52.6%) suggests that transportation may also be a factor in the high rate of ED abuse. Since ambulance companies are usually not reimbursed for trips to private physician offices or primary care clinics, this could partially explain the high frequency of ED visits in those patients who lack other means of transportation.

In the sample that was identified, 78.1% of the visits were not admitted to the hospital, but were sent home. This admission rate of 21.9% was almost half the admission percentage of 46% in the overall elderly ED population found by Baum.⁷ Fourteen percent of the visits were treated with "over the counter" treatments (eg, Maalox, ice, Tylenol).

The aim of this study was to establish a biopsychosocial profile of the elderly ED frequent flier. At the risk of generalizing, the profile of a typical geriatric frequent flier would be that of a widowed white female over the age of 65, who has supplemental insurance, a primary physician and visits the ED during the day. The data gathered seems to agree with Powers, et.al. that convenience is the number one reason for the frequent use of the emergency department and that the lack of other health care resources is not necessarily a factor.⁸

An important observation that needs to be emphasized is that 18.1% of our sample of frequent fliers was suspected to be abusing alcohol at the time of their visit. This compares to 25% of the general ED population noted to be alcoholic by Whitney.¹⁵ This is almost double the statistics by McDonald who stated that 10% of the population over 65 has a drinking problem.¹ Also, 22% of the patients were reported as showing drug-seeking behavior or otherwise showing signs of drug abuse. The most frequent comment noted in the medical records of these patients was the request for narcotics.

A notable finding of our study was that 5.7% of the present-

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ing complaints and 18.4% of the diagnoses made were psychiatric in nature. This area needs to be further investigated as the effectiveness of deinstitutionalization of mental health patients, and subsequent outpatient care may be questionable as reported by Canton.¹⁶

In view of our findings, we recommend a pilot project to study different measures of outreach programs and its efficacy in reducing inappropriate demand and use of ED resources by the elderly. In this pilot study, one modality would be for the outreach team to actively identify those patients who are abusing the ED and to meet with them. The team might consist of a nurse and a social worker who go to the patient's home and write a field evaluation of the patient's current medical status, home environment and education (including education about their health problems) as reported by Small and Seime.¹⁷ The team would then set up an education and referral program. The patient would be informed about his or her condition(s), expected symptoms, the gravity of the signs and symptoms as well as what palliative measures could be taken at home. Education can reduce "unnecessary use of the healthcare system for even severely health-compromised patients."¹⁷ The team should also determine any suspicion of substance abuse, accessibility to the patient's primary caregiver, and transportation difficulties.

The proper use of the health care system should also be discussed, with emphasis on the role of their primary care provider. It should be explained that while the ED may provide the "fastest" service, there is no continuity of care and without follow-up the visit may be fruitless in the long run. At this time any necessary referrals to other service agencies can be made (i.e. Alcoholics Anonymous, Meals on Wheels, senior citizen transport services, etc.). Our plan concurs with Whitney that education is the key and prevention is the goal, and to prevent these unwanted and unneeded visits to the ED we must determine the source of the problem to find the solution.¹⁵

Acknowledgements

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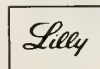
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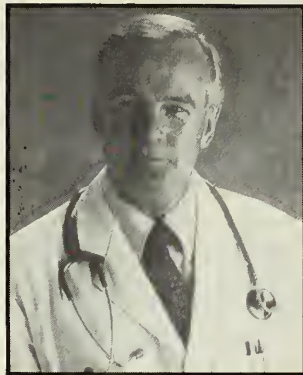
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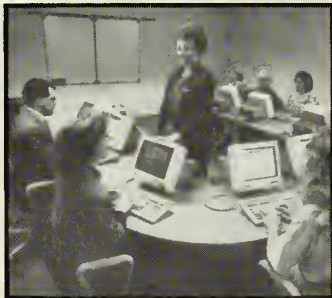
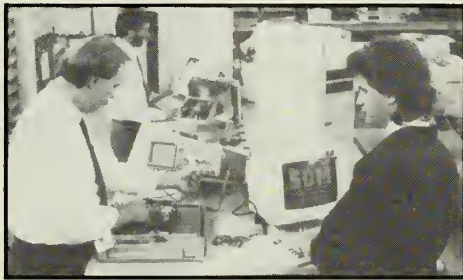
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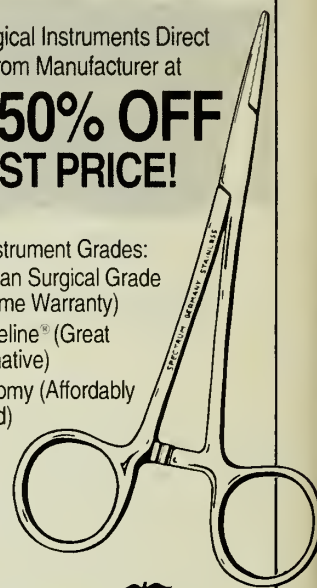
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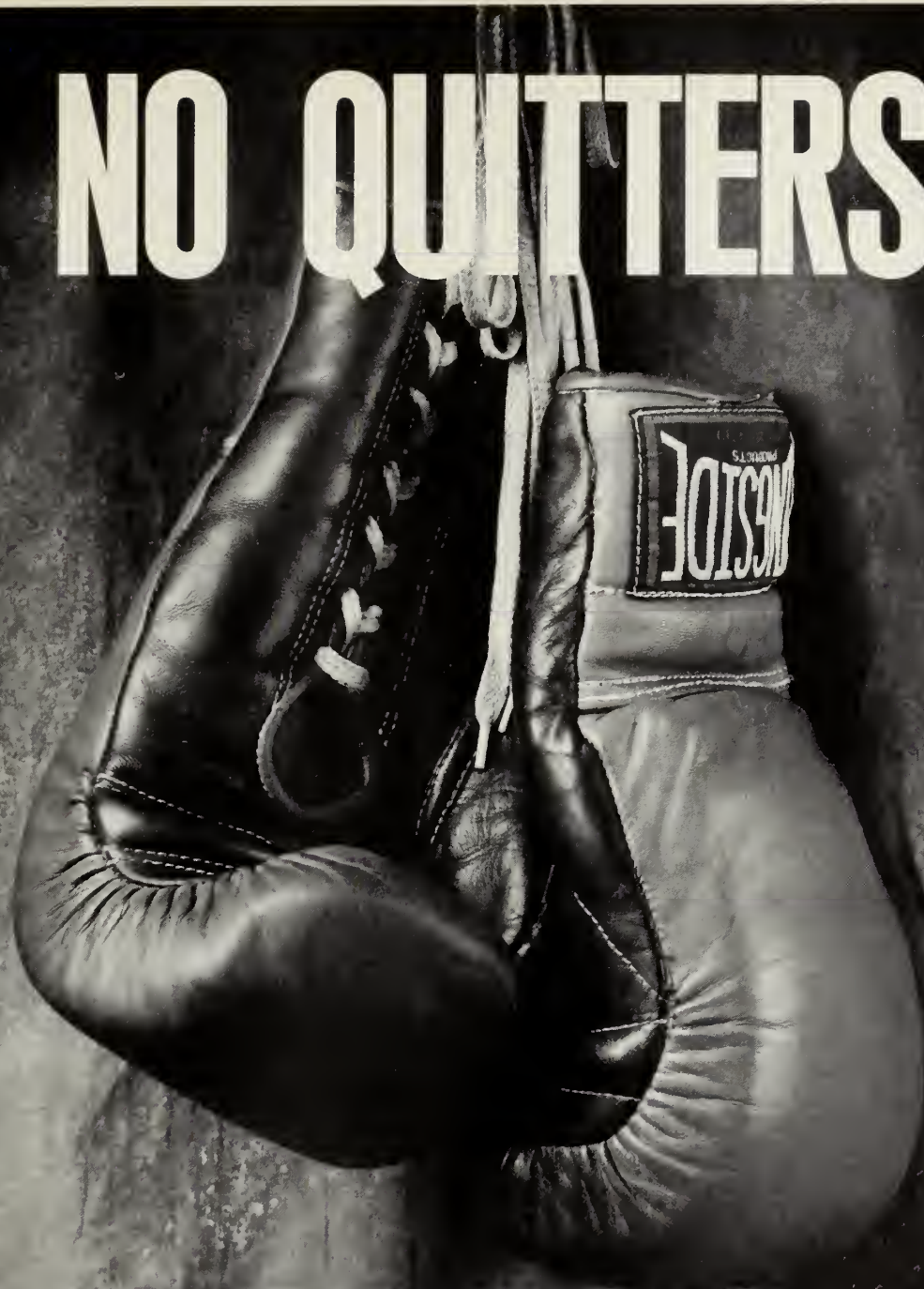
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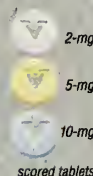
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OHIO Medicine

JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

VOL. 87, NO. 8

AUGUST 1991

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THE FRANCIS A. COUNTWAY
COVER STORY
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Sir Joshua Reynolds was the most respected painter in England during the late 18th century. He was admired most for his portrait paintings, as illustrated by Master Henry Hoare's portrait of 1788 on the cover. Reynolds was a good friend to many of the important figures in medicine, politics, literature and the theater, and often painted their portraits. Of interest to physicians would be Reynolds' medical history. His story begins on page 394.

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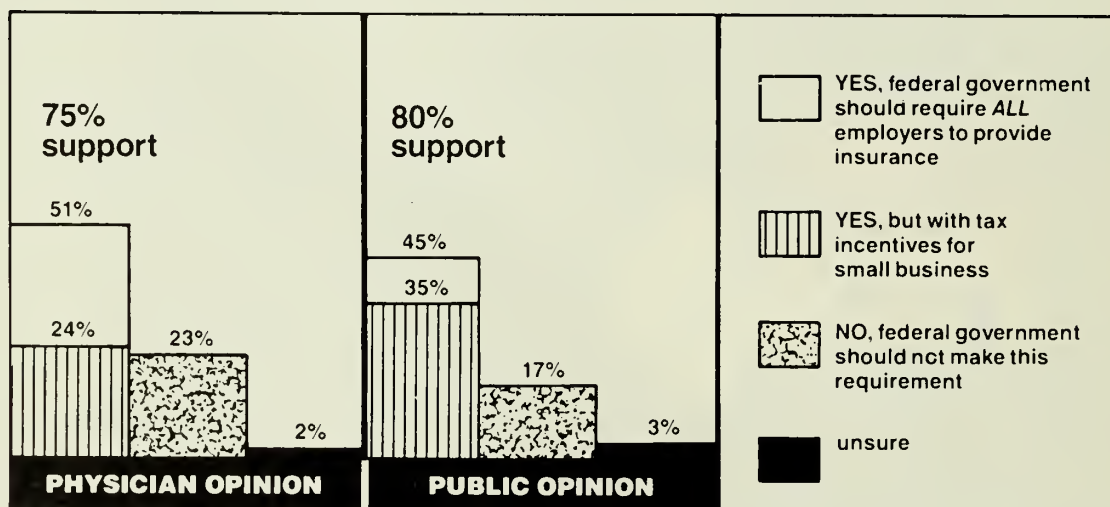
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AMERICANS SUPPORT REQUIRED COVERAGE

Doctors and patients agree that employers should be required by law to provide basic health care coverage.
Sources: Dec. '89 Gallup Survey/Physicians Jan. '90 Gallup Survey/Public

A message from The American Medical Association for the Health Access America Proposal

Measuring Success

IT ALL DEPENDS
ON THE DEFINITION

How successful is the OSMA? If one counts the total number of members and the percent of medical professionals the OSMA scores high.

By Joseph
Sudimack, Jr., MD
President of
the OSMA



Reliable information that is disseminated by our communications department to the profession through the *OSMAgram*, *Legislative Bulletin* and *Third-Party Update* is without a doubt the

most up-to-date and accurate information available. Add to this the number of inquiries and responses emanating from the ombudsman department and one can easily ascertain that we hold our own in this "information age." I suspect that some of you feel inundated with all of the information that is made available to you.

Our legislative report card is not 100%, but nobody receives a 100% score in the legislative environment. When one considers the apathy measured by percentage of members belonging to OMPAC and the difficulty in obtaining members to testify before the House or even write letters, we do remarkably well. Our legislative staff is one of the most respected in the state by virtue of their presentation of accurate information, diligence, availability and honesty.

Can the grass-roots, busy practicing, front-line physician participate in formulating policy in the OSMA? In response I would suggest that if you have not, you should attend just one Annual Meeting. The meetings are scheduled so that they are convenient with minimal loss of time from the office — Friday evening through Sunday morning. Attend one reference committee and see the line of members (not just delegates) who express their concerns to the committee members. Attend one Sunday session of the House and hear the sometimes heated and emotional debate over large and small issues. Those who sit at home, and say it makes no difference what I say, are sadly mistaken.

Quality of staff, performance and fiscal responsibility. The experience of visiting other states

continued on page 374

A MULTIPLE CHOICE QUIZ

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It has taken years for Madison Avenue techniques to make serious inroads into our profession; but now that it has happened, the advertising and promotion of medicine are becoming a major part of the market share of television,

newspapers and other media. There is hardly a publication, newspaper, program or evening on the major TV networks that there is not a very well-produced and well-presented advertisement

for some segment of the medical health system.

Unfortunately there is very little guidance given to marketing departments in our hospitals for balanced, ethical presentations. And even more unfortunately, there is little ability of an ethical profession to assure truth from an entrepreneurial segment of its

members whose concern for increasing a "market share" overshadows the desire to not mislead the public. Even the terminology of "customer" and "client" replaces the more obvious concept of "patient."

Several years ago a member of a hospital marketing department came to our office to discuss the marketing of our practice. Their initial concern was our level of presence in the Yellow Pages of the local phone book. The obvious emphasis was "bigger is better," and we were not "bigger." And yet after scrutinizing the Yellow Pages we felt that our modest listing was more consistent with the best practitioners of our profession and specialty. Maybe a busy physician does not need to advertise — and then why is a physician busy?

The editor of a plastic surgery journal recently rebuked his colleagues to present all of their results and not just the very best. This editor, a former teacher of ours, was concerned that he could not reproduce the presented results in his own practice—a quality practice in a big East Coast medical center. His concern is not a personal problem with his own practice, but with his understanding that his own colleagues are not being fair with the public in promoting their own practices.

The recent introduction of laser surgery has opened wide horizons

By Richard Reiling, MD
Chair, *OHIO Medicine*
Advisory Committee



From Our Editors

... continued

for advertising. The laser is perceived by the public as a space age instrument that destroys unwanted tissue in an instantaneous display of light and smoke. The providers of laser surgery have exploited this concept and promoted many unproven concepts—less pain, less bleeding! On a daily basis we physicians are implored by our patients (clients!) to perform surgery with lasers or to refer them to a “high-tech” surgeon who will use the laser. To top the deceit there is often a sizeable surcharge for laser surgery because of a false self-esteem in which the provider believes that the use of the laser should be financially rewarded.

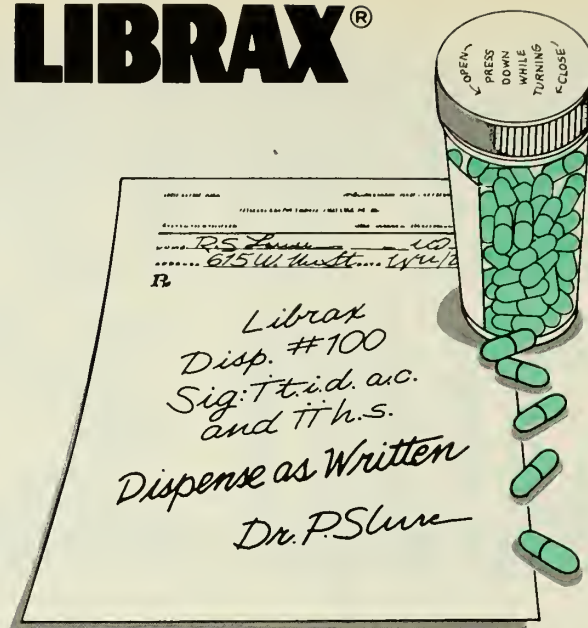
Indeed, we should be ready to discuss and even advertise our abilities in honest and non-misleading ways. We should be ready to discuss our charges so that an informed consumer (soon to be a patient!) will be able to make a good medical choice. This is the only ethical and moral way of practicing medicine in the 1990s. Our ancestors would be appalled at the schmaltz that now is so prevalent in our profession.

We can help our professional image and ethics by calling to the attention of hospital administrators those advertisements and claims that are, at the very least, misleading. We can also avoid using the services of our colleagues who we believe are not overly honest in their claims for services and costs.

It is abundantly clear that in this very difficult financial environment, if we as physicians do not make efforts to keep our profession moral and ethical, then outsiders will impose restrictions on the practices of the profession. Or even worse, the profession will be overtaken by charlatans and snake-oil entrepreneurs. OSMA

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur. Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide, more severe seen after excessive doses over extended periods; mild after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Revised: February 1988



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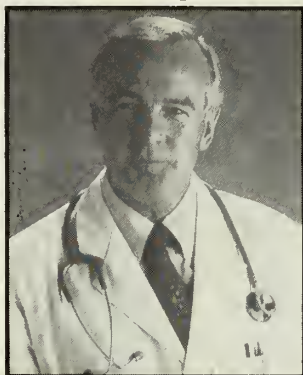
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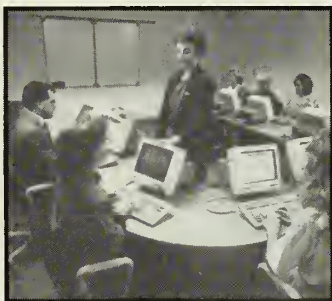


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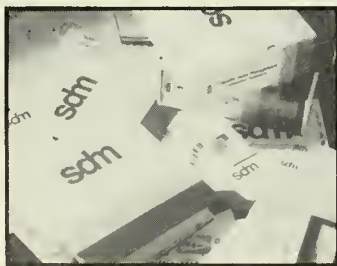
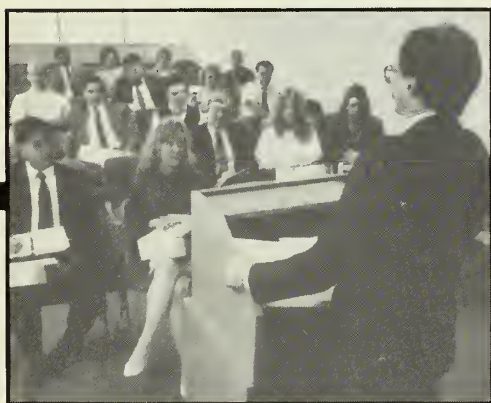
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Letters to the Editor

The risks of quality assurance

To the Editor:

Your article in the May issue of *OHIO Medicine*, "The Risks of Quality Assurance," rang a bell with me. A couple of years ago, alarmed about the potential of bankruptcy for doing peer review after the *Patrick v. Burget* decision, our peer review committee asked the hospital administration if we were covered by the hospital's liability insurance policy. We received a memorandum stating that according to the hospital insurance expert we were. However, because of the importance of the question, we asked to see the insurance policy. The Board of Directors then had the hospital's attorney write a formal statement. This document stated that all staff members who were on any committee engaged in quality review would be fully indemnified for all legal expenses, fees, fines, judgments etc. *if the physicians acted in good faith.* (My emphasis.) As we pointed out to them, any adverse judgment in an antitrust suit automatically involves a finding of bad faith action. Therefore we would not have the coverage at the time when we would need it the most. We pointed out that physicians are discharged from the staff by the Board of Trustees, and the board, before making such a determination, should assure itself that the peer review was done in good faith, and then should take full responsibility for its decision. The attorney and the board refused to budge. Therefore, peer review physicians are not covered in our hospital, and I have not done peer review work there since then.

I would be interested in knowing

how many other hospital medical staffs are in a similar position, i.e. receiving assurances that are not backed up when the fine print is examined. In the present adverse economic climate, when many hospitals are operating in or near the red, I imagine there are quite a few.

James B. Evans, MD
Dayton



Litigation and the Florida experience

To the Editor:

In discussing tort reform for professional liability litigation, Dr. James Ravin correctly identifies a major problem, i.e., "the extreme low risk to a plaintiff for filing a lawsuit." Adopting a system of "the loser pays" might well be beneficial, however it must be established in such a manner as to avoid the experience found in Florida.

The Florida Medical Association was successful in obtaining such a provision but, at the last count, the only monies changing hands under this law came from hospitals

and physicians. The unsuccessful plaintiffs merely pleaded a lack of funds. Therefore, if we are to consider such a plan, let's be certain that the plaintiff *attorney* will be liable for costs assessed against their clients.

Attorneys argue that the contingency percentage must be high to cover expenses. By facing a personal added expense in an unjustified case, these individuals might well think twice before filing such suits.

Donavin A. Baumgartner, Jr., MD
Cleveland
OSMA Past President

OHIO Medicine

welcomes Letters to the Editor.

Executive Editor

OHIO Medicine

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Association News

IMGs often unaware of AMA activities on their behalf

Su-Pa Kang, MD

Editor's note: In addition to his duties as Fourth District Councilor, Su-Pa Kang, MD, Toledo, is one of eight physicians who serve on the AMA's Advisory Committee on International Medical Graduates. The following article, submitted by Dr. Kang, updates OSMA members on the work of this committee.

Anyone who wonders why the AMA Board of Trustees established a special Advisory Committee on International Medical Graduates (IMGs) in October 1989 has only to look at the AMA's demographics to gain a quick understanding.

As of December 31, 1990, only 30.4% (37,781) of the country's IMG population were members of the AMA, leaving close to 87,000 who were not.

Why aren't more international medical graduates joining the ranks of organized medicine? Last June, the AMA's Advisory Committee on IMGs sent a survey to a random sample of 2,200 IMGs (both AMA members and non-members) in an attempt to find an answer. The survey's purpose was actually twofold: 1.) to learn which issues are most important to IMGs and 2.) to uncover IMGs' views on the AMA's performance on these issues.

Most important issues to IMGs

When the returned surveys were tallied, nine issues emerged as "very important" ones to survey respondents. The top two dealt with discrimination. Respondents indicated, for example, that there is a strong need to support federal

legislation prohibiting discrimination against IMGs (83.1%), as well as a need to support state-level activities to prevent discrimination against IMGs for the purpose of state licensure (79.5%). Respondents also believed that counseling individual IMGs who face alleged discrimination in application for hospital medical staff privileges and employment decisions (65.6%) merited a "very important" ranking. Other "very important" issues rated by the respondents included:

- representing the viewpoint of the majority of physicians to the federal government (75.5%)
- working toward the enhancement of physicians' public image (60.7%)
- increasing IMG representation on AMA councils and committees (59.3%)
- developing a credible centralized credentials verification system for state licensing authorities (55.3%) and hospitals (51.3%) to use.
- working with state and county medical associations to develop a better infrastructure for all IMGs (53.8%).

IMGs unaware of AMA activities

One of the survey's most startling results was that the majority of IMGs are unaware of many of the activities that the AMA has undertaken on their behalf. Following is a list of current topics of importance to the IMG community:

- a centralized verification mechanism — while not a panacea for all problems IMGs face in state licensure, the National Physician Credentials Verification Service can reduce the requisite time for state licensure by collecting and maintaining medical records

OSMA's international medical graduate population

The Ohio State Medical Association currently has a number of international medical graduates within its membership.

As of this writing, and counting only those who are in active practice, as well as resident members, IMGs comprise approximately 22% of OSMA's total membership — about 2,800 IMGs in all. OSMA.

information that IMGs are routinely asked for in state licensure and medical staff application. (Note: As of this printing, the Ohio State Medical Board is not one of the 10 state medical licensing authorities which accept this service.);

- IMG counseling — this is currently available through the Director of IMG Services at the AMA, the AMA Office of General Counsel and the AMA Advisory Committee;

- federal and state legislation — in 1990, the AMA supported, with modifications, H.R. 5452, the "Facilitation in Licensing for IMGs Act." The AMA continues to evaluate federal legislation dealing with discrimination against IMGs. It has also created a state model bill calling for equal treatment of IMGs and USMGs for purposes of licensure by endorsement;

Association News

- IMG data base — the Advisory Committee has created a database of names to be used by the committee as a resource for nominations to AMA medical education-related councils and committees;

- IMG organizational liaison — the Advisory Committee has established an ongoing relationship with numerous IMG organizations; and

- federation infrastructure — there are now three state medical associations with IMG sections and six with IMG committees.

Since its inception in 1989, the Advisory Committee's charge has been to provide advice to the Board of Trustees and to the AMA staff on policy matters and program activities that bear directly on IMGs. The Advisory Committee has interpreted those duties to include the job of implementing past AMA policy concerning IMGs, as well as creating new programs and activities that will improve the environment for IMGs in this country. While progress has been made, the committee believes that there is still much work to do.

Please watch *OHIO Medicine* for future developments on these and other important issues to the IMG community. **OSMA**

Science fair projects capture OSMA's top awards

Ilea A. Mathis, an 11th grade student at Westerville High School, was named by the OSMA's and the Academy of Medicine of Cleveland's judging team as winner of the association's top award during the 43rd Annual State Science Day on April 20, 1991, at Ohio Wesleyan University.

The event, which featured more than 800 exhibits by seventh through 12th grade students from throughout Ohio, is sponsored annually by the Ohio Academy of Science.

This marked the 10th consecutive year that OSMA has sponsored awards for the State Science Day. This year, the OSMA combined efforts with the Academy of Medicine of Cleveland. Members of the Young Physicians Committee of the Academy served as judges.

These judges selected Ilea's winning exhibit entitled "Application of the PCR to Detect Genetic Anomalies in MCF-7 Breast Carcinoma Cell Cultures" as the overall winner. For her efforts she received a hand-lettered plaque and \$100. This is the second time that Ilea Mathis won an OSMA award at Science Day. In 1990, she was named the winner of the tenth grade level award.

The judging team also named the following winners:

7th grade — Stacy M Kachner, "Fractures in Children," Waterloo Middle School, Randolph, Ohio

8th grade — Stephen D. Heaphy, "Phototoxic Chemicals in Vegetables," St. Charles, Lima, Ohio

9th grade — Andra L. Dutrow,

"Does Stimulative Herbal Tea Effect the Activities of White Mice Part 2," Alliance High School, Alliance, Ohio

10th grade — Sophia S. Chun, "The Effect of Various Chemicals on the Regeneration of *Dugesia Tigrina*," Wapakoneta High School, Wapakoneta, Ohio

12th grade — Joann E. Roy, "A Study of Habituation and Dishabituation in *Drosophila Melanogaster* by Olfactory Stimuli," Perkins High School, Sandusky, Ohio

More than 800 junior and senior high school students representing 77 counties and 345 schools across Ohio competed in the science day, according to James M. Freed, director and professor at Ohio Wesleyan.

"The students qualified for the state competition by earning superior ratings at 15 district science days throughout Ohio earlier in the year. The students' projects were judged by more than 500 professionals in medicine, education, industry and science," Freed said.

Special awards, about 200 in all, were presented on behalf of more than 80 professional societies, corporations, universities and governmental agencies, with a total value exceeding \$200,000. Congratulations to all the winners. **OSMA**

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Association News

PEP names new director

The Physician Effectiveness Program has named Richard O. Pelham, MD, FACS, PA, of Erwin, North Carolina, as its new full-time medical director. Dr. Pelham will assume his new responsibilities this fall.

The new director comes highly recommended by fellow physicians in the North Carolina area with whom he has worked on the Physicians Health and Effectiveness Committee of the North Carolina Medical Society. These physicians report that Dr. Pelham has been a major help to many recovering physicians. Words such as intelligent, compassionate, caring, devoted and sincere were sprinkled throughout his letters of recommendation.

Dr. Pelham's personal interest in recovery made him an ideal candidate for work in the medical health and effectiveness field. In the past seven years of Dr. Pelham's own recovery, the solo practitioner developed a strong desire to become involved in the field of addiction. And, it was for this reason that he sought a career change after 25 years in surgery. Dr. Pelham pursued his dream by taking CME classes devoted to this field, and for the past two years his primary interest has been to work with physicians who have found themselves trapped by a disease that almost destroyed them.

In 1988, Dr. Pelham was certified in addictionology by the American Society of Addiction Medicine.

Dealing with people on a one-to-one basis, as well as a group, has been part of the doctor's life during his whole professional experience as both a physician and as a minister. Naturally, Dr.



Richard O. Pelham, MD

Pelham's genuine compassion for people will be an asset in his new position.

Speaking to audiences is not only something Dr. Pelham feels comfortable with, but is fairly accomplished at. And why shouldn't he be, for the past 35 years he has been "in training" in public speaking with his work in the ministry as well as medicine.

Dr. Pelham completed his undergraduate work at Nyack Missionary College in Nyack, New York in 1950. Immediately following graduation he enrolled in Houghton College, Houghton, N.Y., where he received a BA in theology in 1951, and that same year enrolled in Bucknell University, Lewisburg, PA, for his pre-med studies.

After graduating from Temple University School of Medicine in 1958, he went to General Hospital in Williamsport, PA, where he served his internship. He completed his general surgery residency in McLaren General Hospital in Flint, MI. He also managed to squeeze in a year of study in Europe (Belgium, to be

exact) to study French.

He has practiced in general surgery since 1963. Four years of that time was spent as a medical missionary in Zaire. He also had a solo practice in general surgery in Flint, MI from 1970-1975; and then moved to Kenton, Ohio, where he lived until 1984. Since that time he has been in solo practice in general surgery in North Carolina.

His leadership roles include Chief of Staff, Medical Director of Hospice, and several years ago he served as Coordinator of Surgical Education at McLaren General Hospital.

Dr. Pelham feels he has genuine compassion for those people and physicians who need help, but feel trapped (as he did), not knowing where to turn. This compassion, he hopes, will help those professionals who are in need of attention. **OSMA**

Medical family focus of seminar

What's it like being married to a physician? Wonderful. Miserable.

Many issues facing physicians and spouses will be addressed in a seminar, "The Medical Family: Building Strength in Times of Crises," sponsored by the Ohio State Medical Association Physician Effectiveness Program Technical Committee and the Ohio State Medical Auxiliary on Sept. 27, 28 and 29 at the Ramada University Hotel in Columbus.

This seminar has been designated for 13.5 hours of category I CME credit by the OSMA Committee on Education.

For more information contact Kay Burkett at the OSMA (800) 766-OSMA. **OSMA**

Association News

Learning how to communicate with patients

Consider this scenario. You check your appointment book and Mr. X is due in at 2:00 p.m. Vivid memories of his *last* visit become excruciatingly clear. Patient X never seems to understand what you tell him; he's demanding; he wants things done right away; he interrupts your explanation; and no matter what he comes in for he always adds, "Oh, by the way."

These and similar frustrations were shared recently by Ohio physicians at a Physician-Patient Communication Seminar in Cincinnati sponsored by the OSMA and Miles Pharmaceutical. This seminar was one of three held throughout the state during the month of June.

Jerry L. Hammon, MD, facilitator, told physicians the way to solve these frustrations is to cultivate better communications.

"If you are like many physicians, you may be overlooking the importance of cultivating good communication skills. You may think that communicating is a natural gift that can't be further developed or that better patient communications will take up too much time in your already too-busy practice. Wrong," says Dr. Hammon.

He points out that the ability to communicate well with patients affects almost every aspect of a physician's medical practice such as:

- The physician's satisfaction with the practice of medicine;
- The patient's satisfaction with you as a physician;
- The physician's chances of being sued for malpractice.

Dr. Hammon taught the physicians the techniques necessary to improve communication skills. He



Jerry L. Hammon, MD

did this in a half-day seminar through lecture, demonstrations and clinical role-playing. In return, the physicians received four hours of Category I CME credit sponsored by the OSMA Committee on Education, and perhaps a better understanding of communicating with patients.

"Poor physician/patient communications has been identified as the most important event leading patients to litigate," points out Dr. Hammon. Of 1,000 adult patients surveyed, 25% revealed that at some time they had changed physicians because they had a problem communicating.

"Communication is both the most common and the most important procedure used by all physicians to diagnose and treat an illness, and yet it is the most often overlooked," says Dr. Hammon.

Dr. Hammon, along with 11 other physicians around the country, received extensive training from Miles Pharmaceutical to teach this seminar. Until last July,

Dr. Hammon was senior vice president for Medical Affairs at Good Samaritan Hospital in Dayton, a position he held for eight years. Prior to that he served nine years with the Veterans Administration. And, before that he says he was just a "good old country doctor." Now the independent consultant for medical affairs is traveling around the country teaching physicians how to talk and listen to their patients. "Just as is said in real estate, the important thing is location, location, location, in medicine the important thing is communication, communication, communication."

Dr. Hammon believes that if a physician follows the four E's of medical communication — engage, empathize, educate and enlist — he or she can't go wrong.

In the engagement segment physicians should introduce themselves, use the patient's language, use open-ended questions, and assume that multiple complaints will be made and be willing to handle them. The benefits to using this approach, points out Dr. Hammon, is that physicians will receive more accurate diagnostic information, improve their relationship with the patient, and encourage the patient's responsibility as a partner.

Simple ways a physician can show empathy are by stopping in to see a patient before he or she disrobes, using eye contact, using language the patient understands, being non-judgmental about the person, and occasionally using some self-disclosure. This technique reduces anxiety of the patient, increases adherence and instills greater connection between physician and patient.

These points were illustrated in a videotape depicting an interview with a patient who has both a

Association News

physical complaint and a behavioral problem. The physicians in attendance were asked to rate the performance and jot down the communication behavior of the physician that they liked and also jot down how their approach to communicating with the patient would in some instances differ from that of the physician on the videotape.

Following the video and some discussion, Dr. Hammon introduced the third E — education. He explained that educating entails answering nine important questions every patient has in their mind concerning the four mysteries of health and the five mysteries of the medical world.

Mysteries of Health

- What has happened to me?
- Why has it happened?
- What are you going to do about it?
- What's going to happen to me?

Mysteries of the Medical World

- What are you doing to me?
- Why are you doing it to me?
- Will it hurt/harm me? How much? How long?
- When/how will you know what it means?
- When/how will I know what it means?

Once these questions are answered for the patient, the physician can go on to the last E — enlistment, the act of getting the patient's cooperation, confidence and adherence. Most patients will have arrived at a self-diagnosis before approaching a doctor's office, explains Dr. Hammon. If there is a conflict between the patient's beliefs and the physician's beliefs it will lead to non-adherence, explains Dr. Hammon. To avoid this situation, a physician needs to say to the patient, "I've arrived at one

possible explanation of what the difficulty is. How does my conclusion fit with what you have been considering?"

A physician's actions will influence adherence, according to Dr. Hammon. The typical range for patient non-adherence to treatment regimens is between 30% and 60%, as illustrated by the fact that of the 750 million new prescriptions written in the U.S. and U.K. each year, 240 million, or one-third, may never be taken or even filled and another 240 million are only partially taken, and the rest we hope are taken correctly. To increase the likelihood of adherence, physicians need to keep the regimen simple, write out the regimen and give it to the patient, motivate the patient, prepare the patient for side effects, and get some feedback from the patient about what the patient understands.

At the conclusion of the seminar physicians had an opportunity to put what they had learned to work. Members were divided into teams, with each team member assuming one of three roles — the patient, the physician or the observer. Each member had an opportunity to take each of the roles and critique the performance. The role-playing encouraged the physicians to use interactive techniques that might be new to them.

Dr. Hammon guaranteed the attendees that by following the simple steps learned in the seminar for a six-week period, a marked improvement in their relationships with their patients will be evidenced by better patient adherence and improved satisfaction for both patient and physician due to improved communications.

Anyone interested in having the OSMA sponsor the communications seminar for their

hospital or some other medical group can contact the OSMA Department of Communications at (800) 766-OSMA. OSMA



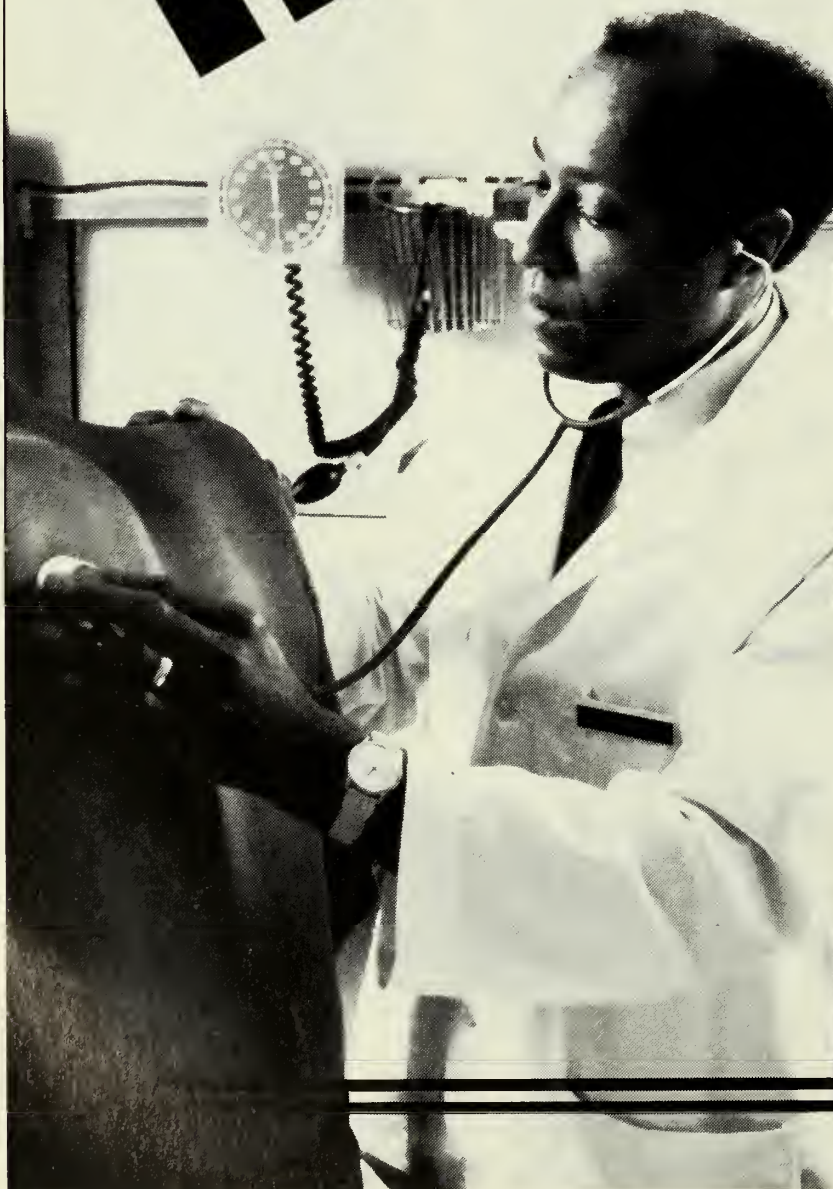
OHIO Medicine wins award

OHIO Medicine received a Bronze Quill Award of Merit from the International Association of Business Communicators, Columbus Chapter. The magazine won for Best Ongoing Publication, in the not-for-profit category.

Communicators received their awards at a banquet held June 13 in Columbus.

The International Association of Business Communicators is a professional organization for manager, writers, editors and audiovisual specialists whose purpose is to advance the profession and quality of business and organizational communications. OSMA

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Auxilians: An Integral Part of Your Success

YOUR SPOUSE IS MORE
IMPORTANT TO
ORGANIZED MEDICINE
THAN YOU MIGHT GUESS

By Joyce E. Penn
OSMA Auxiliary
President



Over the past few years the most popular cliché in the auxiliary has been "people are so busy." A large number of Ohio spouses work in your medical offices. We help you as office

managers, registered nurses, assistants, bookkeepers, personnel supervisors and liaisons with insurers. The value of the medical family working together is implicit in the success of many practices.

As a leader of the medical team, you are constantly evaluating opportunities to succeed in the practice of medicine. Although you support organized medicine and are receptive to its goals, you tend to disassociate yourselves from your spouses, in spite of this partnership of commitment. An extraordinary number of spouses help you professionally, yet remain in ignorance and have an inequitable role in furthering medicine's image.

Finding a balance between personal needs and the problems of medicine is the heart of our membership appeal. Your spouse should be an integral part of your success. I encourage you to invite her/him to send \$32 for state and national auxiliary membership. We will contact his/her local auxiliary. If you do not live in a county with an organized auxiliary, we welcome his/her participation as a member-at-large. Medical student and resident physician spouses may join for \$9.50.

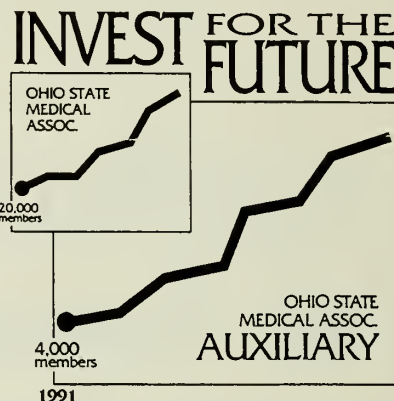
The auxiliary's "Fall Focus on Membership" will be held in Mansfield, Ohio, September 17,

Auxiliary Page

1991. With Barbara Lach, membership chair, spearheading our membership appeal, our county officers will receive membership reports from 22 organized counties in the northern half of Ohio. Members-at-large are encouraged to attend and learn about the auxiliary. A planned speaker, Cathie L. Martin, North Central Regional Vice President of the American Medical Association Auxiliary, will discuss the significance of federated membership, the OSMA auxiliary membership survey, discuss incentives for increasing membership, project goals for this

year, give treasury and billing suggestions, and distribute new membership brochures. Michelle Ballinger, past president of The Richland County Medical Society Auxiliary, has generously given her time to coordinate meeting arrangements. **OSMA**

Membership checks should be made out to OSMA Auxiliary and mailed to Carol Wenger, Executive Director, OSMA Auxiliary, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824.



Presidential Perspectives . . . continued

and observing other organized medicine staff people at national meetings permits an excellent opportunity for appraisal and comparisons. In my opinion, we are right there with the best. Our staff members have changed over the years, and in each instance we have been fortunate in acquiring additional well-trained and dedicated staff.

Our staff/member ratio is one of the smallest, and we therefore get more "bang for the buck" than most.

How about the quality of officers, councilors and committee chairpersons? Over the years I have seen a parade of unselfish, well-educated, busy practitioners dedicated to medicine and quality medical care who have served and been willing to serve as your elected leadership. It never ceases to amaze me when Council and/or committees come up with a solution to a seemingly unsolvable problem.

The OSMA has been, is, and will continue to be a successful organization of professionals.

However, how successful are you as an individual physician?

I know that the news media does little to contribute to your feeling of success, but I would like to share with you the thoughts of Ralph Waldo Emerson regarding success, which I think are applicable to all physicians:

"To laugh often and much; to win the respect of intelligent people and affection of children; to earn the appreciation of honest critics and endure the betrayal of false friends; to appreciate beauty, to find the best in others; to leave the world a bit better, whether by a healthy child, a garden patch or a redeemed social condition; to know even one life has breathed easier because you have lived. This is to have succeeded."

Remember the glass is half full, not half empty. **OSMA**

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Summary of Actions — Ohio Resolutions to the AMA

Editor's note: In June, the American Medical Association's House of Delegates convened in Chicago for its Annual Meeting. Among the resolutions considered at that meeting were a dozen, brought before the House by the Ohio Delegation. Following is a summary of the actions the AMA House took on each of the Ohio resolutions.

Timely Early Disclosure of All Limiting Charges Information (OSMA Am. Res. 14-19)

The AMA House of Delegates **adopted** the following Ohio resolution:

RESOLVED, That the American Medical Association work with HCFA to allow a 30-day decision period between the time that the full and complete schedule of limiting charges is made available by the carrier and the deadline date for the decision on whether to become a "participating physician."

Limiting Terms of Office in the AMA (OSMA Res. 37-91)

The AMA House of Delegates **referred** the following Ohio resolution to the **AMA Board of Trustees** for a report back at the 1992 AMA Annual Meeting:

RESOLVED, That the AMA Board of Trustees review all AMA Councils and the Board, with respect to the following: (1) the terms of office; (2) the maximum number of terms; and (3) whether the Councils are elected or appointed, for the purpose of facilitating more rapid involvement in leadership positions of young physicians, women, international medical graduates and other minorities.

Coverage of Drugs by Medicaid (OSMA Em. Res. 04-91)

The AMA House of Delegates **adopted** the following Ohio

resolution:

RESOLVED, That the American Medical Association beseech the Health Care Financing Administration to develop meaningful guidelines for state Medicaid agencies to pay for drugs necessary to treat life-threatening and other serious medical conditions, even if such drugs are manufactured/distributed by non-rebating firms; and be it further

RESOLVED, That the AMA ask the Health Care Financing Administration to grant states reasonable autonomy in decisions to cover these medically necessary drugs without retroactive economic penalty.

OBRA 90 Medicaid Reimbursement for Prescription Drugs (OSMA Em. Res. 05-91)

The AMA House of Delegates **adopted** the following Ohio resolution:

RESOLVED, That the American Medical Association strongly encourages the Health Care Financing Administration to proceed with the mandate of OBRA 90 for Medicaid reimbursement for prescription drugs with due caution: and be it further

RESOLVED, That the criteria for establishment of price "upper limits" for multisource drugs should encompass the following considerations:

1. Bioequivalency of *all* the multisource drugs (i.e., "A"

rated generics).

2. Due consideration for drugs which have narrow therapeutic windows of effectiveness.
3. Due consideration for drugs with a history of significant adverse drug reaction reports.
4. Even if an "upper limit" must be established if there are at least three "A" rated equivalents, all of the "A" rated equivalents available must be manufactured by firms that have no unresolved improprieties in their dealings with the Food and Drug Administration.
5. Availability must be certified by more than the mere observation that a listing of the drug appears in some catalogue or database.
6. Due consideration for the bottom-line economic impact of the decision, as it is unrealistic to expect that the mere establishment of a price "upper limit" will guarantee tax dollar savings for a particular drug category.
7. A comment period should be allowed for state Medicaid administrators and state Medicaid Pharmacy and Therapeutics committees prior to implementation of new price "upper limits" on drugs; and be it further

RESOLVED, That the AMA develop an educational program related to generic drugs and their
continued on page 418

Patient transfer laws amended

Prepared by OSMA Department of Legal Services

Most physicians are familiar with the federal government's Emergency Treatment and Active Labor Act of 1986 (also known as "COBRA"). New, however, and probably unfamiliar to most medical staff members are amendments to this act that became effective on May 1, 1991. These amendments do three things:

1. They change the standards for termination of a physician's Medicare contract.

2. They alter the standard necessary to prove a violation of the act and

3. As of February 1, 1991, they required that the Inspector General consult with an appropriate peer review organization to determine if an emergency medical condition existed.

If you are a physician who is responsible for the examination, treatment or transfer of an individual — even as a medical staff physician on the hospital's on-call list — you need to understand how these amendments affect you. To do that, a brief review of COBRA may be in order.

Background

Historically, courts have held the provider's freedom on contract above the patient's right to receive care. Even when the defendant was the only physician available, as was the case in *Hurley v. Eddingfield*, the court held that the physician had no duty and was free to refuse to treat an individual.

Gradually, however, this "no duty" rule began to erode.

In *Wilmington General Hospital v. Manlove*, the court held that liability may be imposed if the patient relied on a "well-established

custom of the hospital to render aid in such a case." In Wilmington, an infant died after the hospital refused to treat the baby in its emergency room. In an earlier case, *Stanturf v. Sipes*, the hospital had a long-established custom of accepting all persons for emergency treatment, upon payment of a \$25 fee. The plaintiff had relied upon that custom, and the hospital was held liable.

At the same time, both the Joint Commission on Accreditation of Healthcare Organizations and the AMA's Council on Ethical and Judicial Affairs issued statements that addressed physicians' responsibility in rendering care. The JCAHO specifically noted the obligation to render care despite the patient's ability to pay, while the AMA spoke to the need of attending emergency cases.

Of course, the Hill-Burton Act of 1946 had already enacted statutes directed toward the provision of health care to those unable to pay, but these statutes had proven to be generally ineffective, and as a result, in 1986, Congress enacted COBRA.

What the act provides

Any Medicare-participating hospital with an emergency room must determine, when a patient enters the E.R., whether an emergency medical condition or an active labor exists. If so, the hospital must treat the labor or stabilize the patient by providing such medical treatment as necessary to assure that no deterioration of the condition is likely to result from the transfer of the individual from the facility. If no such condition is present, the hospital need not provide further treatment or ensure safe transfer to a receiving hospital. The act also defines when the transfer of a patient is permissible (see sidebar).

Violations and the new amendments

Prior to May 1, the possible penalties for violation of the act included possible termination or temporary suspension of the physician's (and/or hospital's) Medicare provider contract for "knowing and willful" or negligent violation of the act. Civil monetary penalties of not more than \$50,000 could also be levied against the hospital or a physician employed by the hospital.

Now, with the new changes, hospitals no longer face the possibility of termination or temporary suspension of their Medicare provider contract, as that language has been removed. While physicians' Medicare provider contracts can still be terminated if a violation is discovered, the new standard of proof changes from a "knowing and willful" act to one that is "gross and flagrant or is repeated." In other words, the new standard of proof seems to require a more serious infraction before a provider contract can be terminated, but this phrase has not been interpreted in a court action to date, so it is difficult to establish exactly what parameters have been set.

The new provisions also alter the standard necessary to prove a violation of the act. The amendments essentially change the standard of proof for violations from a "knowing" standard to one of negligence. Therefore, it will be easier to show a violation of the act since now it is only necessary to show that a party was negligent in his or her responsibilities — not that the party knew he or she was in violation of the act's provisions.

Peer review

As of February 1, 1991, the Inspector General must consult with the appropriate peer review

Legal

organization to determine if an emergency medical condition existed.

The Secretary must allow at least 60 days for the PRO to review the case and report its findings. During that time, the PRO must notify the physician (and hospital) of its review and provide them an opportunity to meet and discuss the case.

Who is liable?

Any medical staff physician who violates the statute faces potential liability. That applies even if you are a medical staff physician on the hospital's on-call list.

Currently, there are no court decisions interpreting a "negligent" violation. "Negligence" traditionally places a higher burden on someone than "knowing." Under the act, it will only be necessary to show the physician failed to do what a reasonable physician under the same conditions would do.

Suppose, however, that you are a physician on a hospital's on-call list. After an initial examination, one of the emergency room physicians determines that an individual needs your services and contacts you regarding that fact. If you refuse to or fail to appear in the E.R. within a reasonable time, and the E.R. physician is required to transfer the patient because the medical benefits of transfer outweigh the risks that exist without your assistance, the transferring physician won't be penalized, but both you and the hospital could and probably would be. Also, if a patient is transferred because the on-call physician fails or refuses to treat the patient, the transferring physician must note the name and address of the on-call physician and include it with those records that are forwarded to the receiving hospital.

When patient transfer is legal

Under the federal government's Emergency Treatment and Active Labor Act of 1986, a transfer of the patient is permissible if:

1. The patient requests a transfer or a physician certified that the medical benefits of transfer outweigh the risks of transfer;
2. The receiving hospital agrees to accept the transfer and has available space and personnel for treatment of the patient;
3. The transferring hospital provides the receiving hospital with appropriate medical records; and
4. Transfer is effected through qualified personnel and transportation equipment, including life support if necessary. **OSMA**

The statute states that even if the on-call physician doesn't treat Medicare patients, he or she may still be subject up to a \$50,000 civil monetary penalty for negligently violating the statute by refusing to treat a patient on account of economic status.

Inspector General v. Burditt

The responsibilities of an on-call physician were addressed in *Inspector General v. Burditt*, which, while decided under the previous version of the act, is still applicable. In *Burditt*, an obstetrician on call for an emergency department ordered the transfer of a patient in active labor with severe hypertension to another hospital three hours away. HHS sought a civil penalty against the

obstetrician, arguing that as a "responsible physician," he knowingly violated the statute by transferring an unstabilized patient who was in active labor and who also had an emergency condition by falsely certifying that the benefits of transfer outweighed the risks, and by failing to ensure adequate equipment and staff during the transport. The administrative law judge held that the obstetrician violated the statute by refusing to treat this high-risk patient and insisting on transferring her to a distant hospital when delivery was imminent and her condition was unstable. The administrative law judge held that a physician is a "responsible physician" under the statute when providing emergency department services as a condition of maintaining medical staff privileges. Accordingly, a \$20,000 civil monetary penalty was ordered against the physician. This case is being appealed.

The hidden liability

In addition to the penalties imposed by the federal government, the act states: "Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the state in which the hospital is located and such equitable relief as is appropriate."

This provision was interpreted in *Bryant v. Riddle Memorial Hospital*. The court held that the legislative intent of Congress was to provide for a private federal cause of action. This ruling is consistent with the overall purposes of the act, which establishes a source of federal

guidelines that Medicare hospitals having emergency medical facilities must follow to prevent the problem of inappropriate patient transfer. According to the court, it follows that individuals who allege violation arising under the act should be afforded an opportunity to seek remedies in federal court.

However, the courts have limited the application of the statute to those cases where the plaintiff was actually transferred or turned away from the hospital, without medical treatment for economic reasons.

If you have further questions about the new amendments, or patient transfers, contact OSMA's Department of Legal Services, (800) 766-OSMA.OSMA

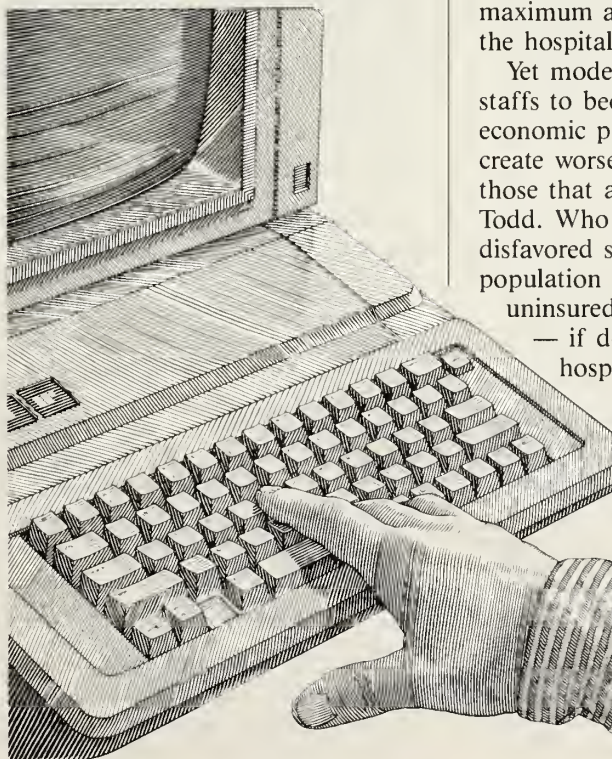
Economic credentialing — and what you can do about it

If you think economic credentialing is one of those California-based schemes that is likely to fall out of favor before it reaches Ohio, think again.

As William Todd, JD, of the law firm Porter, Wright, Morris and Arthur, OSMA's outside legal counsel, explained to members of the OSMA's Hospital Medical Staff Section at the group's Annual Meeting in May, economic credentialing is not just something that is happening in California. "It's here and here now," he says.

How did this happen?

Basically, economic credentialing is using economic criteria for granting or renewing hospital membership privileges. No quality considerations are factored in.



"It's keeping an eye on the bottom line and off the patient," explains Todd.

How could such a system, so directly in conflict with the fundamental responsibility of the physician, come into being? Blame it on technology, says Todd.

"There is now adequate data available in hospitals to do computer models of a physician's performance," he says.

Software now makes it easy for hospital chief executive officers to tell at a glance which physicians are "overutilizing," and which are keeping their patients in a little too long. Of course, what computers *can't* reveal, Todd argues, is the quality of the physician's work, but quality matters little to hospitals looking for revenues to aid their budgets — and that, says Todd, is the cornerstone of this drive for economic credentialing.

"Hospitals are looking for physicians who can contribute the maximum amount of revenue to the hospital," he says.

Yet modeling hospital medical staffs to become, essentially, economic production units, may create worse access problems than those that already exist, warns Todd. Who will want to treat disfavored sections of the population — Medicaid and uninsured patients, for example — if doing so will jeopardize hospital membership?

Is it really taking place?

Several years ago, when Howard Lang, MD, current president of the California Medical Association, spoke out on the topic of economic credentialing, it sounded, to some, like a cry in the

Legal

wilderness. Who was actually doing it?

According to a survey conducted in 1989 by *Hospitals* magazine, not very many. The magazine had polled hospital medical staff organizations and learned that less than 5% of hospital CEOs across the country were using economic factors in their credentialing processes. Times have changed quickly, however. In another poll, taken last year, 500 hospital CEOs were asked to comment on the future of economic credentialing. Almost 42% said the process was on its way, and that they would use it, "as soon as they can, presumably," says Todd.

Survey skeptics, however, needn't look far for other proof that economic credentialing is here and here now. Todd points to three areas where some manifestation of economic credentialing has surfaced:

1. Exclusive contracting — where hospitals trade off quality for budgetary considerations. "It's one of the early signs of economic credentialing," says Todd.

2. Medical staff development plans — "which are being developed, not by health-care specialists who are competent to make these decisions, but by law firms," says Todd. These firms produce plans that are designed to give administrators an excuse to drive the staff toward more economic efficiency.

3. The development of physician profile data in computers—Computers can now produce for study: the length of stay of patients; a comparison of tests ordered by one physician with tests ordered by the overall staff; a list of physicians with PRO sanctions; and the number of consultations and referrals a physician makes. As if that isn't enough, computers can also provide information on

factors that should have no purpose in the credentialing process. For example, they can look at: physician profit (how much he or she brings into the hospital) as well as what he or she costs the hospital; a physician's HMO-PPO-IPA arrangements, and his or her willingness to enter into these contracts; practice risk exposure; and operating room underutilization.

"Some hospitals are using these factors to determine the value of a physician," says Todd.

In fact, Haverford Memorial Hospital in Havre de Grace, Maryland is one hospital where economic credentialing specifically is taking place.

What screens will be used?

In the Haverford program, two screens are used to determine whether or not a physician meets the hospital's economic criteria. In the first screen, the lengths of stay and physician charges are both considered by DRG standards. If the physician exceeds these standards by 105% of the DRG average, his or her case is then thrown into a second level of review.

In the second level, the following factors are brought up for consideration: utilization; any malpractice cases settled for more than \$30,000; timeliness of medical records completion; and bad debts (where the patient can't pay and these debts exceed 15% of the hospital's charges to the patient).

Any physician in the second screen whose profile displays one or more of these factors may find his or her membership privileges denied.

What can be done about it?

Many already see economic credentialing as the biggest threat to the profession of medicine

today, yet, Todd says, there *are* things that can be done to restrict its growth and possibly prevent it from spreading any further.

First of all, take news about economic credentialing back to your medical staff, he says.

"Economic efficiency is a consideration we'll all have to have," says Todd, but limit its input in the credentialing process.

Take it to the legislators. Tell them, says Todd, that physicians are not creating the problems with access — hospitals are — and that, as time goes by, more and more access problems are likely to appear. "Explain to them that the practice of medicine is not an economically driven profession. We don't want to see health care turn into a business. We don't want hospitals to be small versions of major corporations like General Motors."

Finally, says Todd, take it to the streets — to patients, to friends, to acquaintances. Tell them it's time to put health care's emphasis back where the physician has always placed it— on quality and access rather than on cost. **OSMA**

10 reasons you probably never expected to hear for why patients sue

What magazines do you keep in your reception area and what do they feature on their cover? Who is booking your appointments? How is your handshake? How many homemakers do you treat in your practice?

Believe it or not, your answers to these questions might just determine whether or not you'll be the subject of a malpractice suit this year.

Linda Mangels, director of Risk Management for the Texas Medical Association and a medical-legal consultant on malpractice prevention for over 30 physician-affiliated insurance organizations, knows that some of the triggers for a malpractice claim can seem ridiculously petty. However, her information comes straight from the mouths of plaintiff attorneys, as well as from interviews with over 260 patients who have sued their physicians.

"Twelve years ago, when you were sued for malpractice, everybody thought it was because you had done something wrong," Mangels told approximately 100 physicians who attended a risk management seminar in Columbus, one of three sponsored by the Physicians Insurance Company of Ohio. "Now we know better." In fact, malpractice suits seem to stem from everyday occurrences to which you've probably never given a second thought.

Here are 10 that Mangels says have helped to lead to malpractice suits against physicians. Check this list to determine your own "malpractice suit-ability":

1. Are you a family practitioner? Strike one. Although obstetricians-



Linda Mangels, a medical-legal consultant, discusses malpractice issues with seminar participant.

gynecologists, general surgeons and anesthesiologists are still the three specialists liability companies vote "most likely to be sued," Mangels says FPs are hit twice — once in their own suits and once in those suits filed against specialists to whom they refer. And just how well do you know those specialists, anyway? Mangels says you need to know them very well if you're referring patients to them. She tells about the case of an FP who had referred patients to an impaired professional. The plaintiff's attorney asked him, "Don't you know who you're referring your patients to?" The FP said yes. The plaintiff's attorney asked, "But you didn't know he drank?" The FP's response was no, he didn't. "Don't you think you should have known?" asked the plaintiff's attorney. "The point was made," says Mangels.

2. Do you order mammograms? If you do, you'd better sit down with your patient and explain that mammograms (or any medical test

for that matter) aren't 100% accurate. And you'd also better point out that the mammogram does not guarantee that the patient will be cancer-free for a year. "Honestly, that's what your patients think, just ask them," says Mangels. She adds that, in a survey of 23 physician-owned insurance companies, the most often alleged malpractice was the failure to diagnose and aggressively treat breast cancer. "There is a whole lot of room here for patient education," she says.

3. If there is an adverse reaction, do you approach the family immediately? If you do, good for you. "The worse thing you can do is send someone else out there. The person who doesn't show is the one named in a suit," says Mangels.

4. Do you listen to your patients? Mangels says if you don't, there is a plaintiff's attorney out there who is more than happy to extend an hour to a would-be client, "and the initial consultation

Legal

is free," she adds.

5. Do you keep your homemaking patients happy? They are the most litigious patient in your practice, says Mangels.

"They're motivated by their love for their family — and they have the time to take you to court."

6. Do you or your staff make a literature check of the magazines in your office? Mangels mentions a women's magazine she saw in one doctor's office that ran with a cover line, "Should you sue your pediatrician?" "Your patients often have up to 45 minutes to read these articles," she reminds physicians.

7. Does your staff practice medicine on your behalf? You might be surprised by the answer. "Who decides who gets in to see you and in what order?" asks Mangels. "Who decides which patient can wait 'til Friday and who comes in today?" If the answer is your receptionist or other non-professional, you may be at risk for a malpractice suit.

8. How patient are you for payment? "Melvin Belli has said that insensitive, untimely and aggressive billing has contributed to his great wealth," says Mangels. She also tells physicians to give patients some idea of how much an office call or medical test will run. "Ask a patient, and they'll tell you a Pap smear costs about \$25," she says. It's up to you or your staff to introduce a more realistic figure.

9. How comfortable is your reception area? It should be comfortable, "but not in a country club sense, where it just exudes wealth," and it should look current. Plaintiff attorneys often check out a physician facility to see if it's up to date or still has copies of the 1976 PDR on its shelves. "And if you have plants, for goodness sakes, keep them

alive," says Mangels.

10. Do your patients consider you a friend? They will if you greet them with a firm handshake and sit down to talk to them.

"Even if you don't spend one extra minute, you're fooling the patient's perception of how much time you're spending with them if you just sit down," says Mangels.

She suggests, too, that you give your patients your first name. "It's harder to sue Dr. Bill Jones than Dr. Jones. And it's real hard to sue Dr. Bill," she says. You may not want to be that informal — but it is malpractice prevention.

"You have only a handful of minutes to communicate to your patients that you care about them," says Mangels. She suggests you use every opportunity to do so. Then, when those everyday occurrences you don't even think twice about occur, maybe your patients won't think twice about them either. **OSMA**

begun collecting pharmacy records in July 1988. The information on the records, obtained without a search warrant, is used to locate people who obtain prescriptions for narcotics from several doctors or to find doctors who prescribe suspiciously large quantities of narcotic drugs.

Both the Summit County Medical Society and the OSMA have supported the suit, and OSMA's Council voted at its May meeting that it would continue to do so. **OSMA**

Summit County doctors take case to Supreme Court

Summit County physicians intend to take their case all the way to the Ohio Supreme Court.

Despite losing suits in both the Summit County Common Pleas Court and the Ninth District Court of Appeals, physicians and patients in Summit County will seek, once again, to restrain police from checking pharmacy records for evidence of narcotics abuse.

The suit began when a group of local doctors, patients and a pharmacist sued police after learning that law enforcement officers in six communities had

Legislation

Will Ohio physicians be mandated to reveal HIV-positive tests?

Should physicians be required to disclose they have AIDS? That question has spurred debate across the country, but earlier this summer, the issue hit close to home as State Rep. Paul Jones, D-Ravenna, introduced House Bill 419 into the Ohio Legislature.

The bill, if enacted, would require all health-care professionals who test positive for the HIV virus to report their condition to the following:

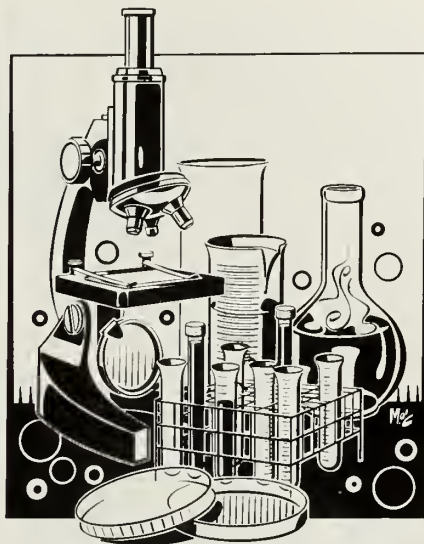
- the State Medical Board;
- the Ohio Department of Health; and
- the hospital or health-care facility where they are employed. (For a closer look at this bill, see sidebar story.)

The legislation was prompted by the death this spring of an Akron-area surgical resident who died from an AIDS-related condition. Although none of the resident's patients have tested positive for HIV infection so far, Jones became concerned when hospitals for which the resident worked failed to disclose the doctor's identity and condition until shortly before his death.

HIV testing and physicians

Jones' concern is hardly unique. A nationwide poll, conducted this spring by Gallup, showed overwhelming public concern about medical professionals with AIDS, and support for mandatory AIDS testing of doctors, dentists and nurses.

So far, no laws (not even Jones' legislation) mandate AIDS testing.



However, the State Medical Board does have a policy, circulated in a newsletter, that asks doctors to report the disease if they have it. Eight Ohio physicians have currently done so, and these physicians are now being monitored by colleagues. They are also restricted, by the board, from performing invasive procedures. Presently, members of the board are in the process of drafting new AIDS guidelines for physicians, but even when completed, the guidelines will still be no more than policy, and board policy does not carry the same force that HB 419 would if it is enacted.

Questions remain, however, as to whether or not a law that requires physicians to disclose their HIV status is necessary. In an anonymous survey, conducted by the Centers for Disease Control and the orthopedic surgeons, only two cases of HIV positive cases were found out of 3,400 physicians surveyed. If that sample is representative, the survey indicates that of over 600,000 physicians in the U.S., only 360 are HIV infected. The low incidence leads

some to wonder if the law isn't getting ahead of medical evidence that so far fails to support the notion that infected doctors pose a risk to their patients. To date, there has been no documented case in the nation of a physician infecting a patient with HIV.

Nevertheless, the AMA, though reassured by the survey, stands by its policy on HIV-infected physicians, which it released in January. That policy states that HIV-infected physicians should "err in favor of protecting their patients. They should either abstain from performing invasive procedures which pose an identifiable risk of transmission, or disclose their seropositive status prior to performing a procedure and proceed only if there is informed consent. As a corollary, physicians who are at risk of becoming infected with HIV, and who perform invasive procedures, should determine their HIV status. The AMA further believes that HIV-positive physicians have a right to continue their medical careers in a way that poses no identifiable risk to their patients."

Recent developments in other parts of the country also seem to indicate that physicians will be under increasing pressure to report their seropositive status. The Superior Court of New Jersey, for example, recently ruled that a hospital acted appropriately when it required one of its physicians to inform patients of his seropositive status. And Florida recently introduced legislation similar to Ohio's HB 419.

HIV and patients

Meanwhile, physicians are becoming more vocal about the need to know the HIV status of their patients.

Shortly after the New Jersey

Legislation

Superior Court released its decision on the hospital and the HIV-infected physician, the Medical Society of New Jersey's House of Delegates took the position that all hospital patients should be tested for the HIV virus. In an apparent attempt at fairness, however, the proposal also called for periodic universal testing of all health-care professionals, including doctors, and MSNJ President Joseph A. Riggs, MD, has added that the society may ask the state Legislature to make mandatory HIV testing (presumably for everyone) a matter of state law.

The AMA, too, issued a statement at the beginning of the summer that proposed that patients be required to give verbal consent to AIDS testing. The board said that "earlier and increased diagnosis can help prolong lives and prevent the spread of AIDS. The reasons for patient testing are stronger today than ever before."

At the OSMA House of Delegates Annual Meeting this past May, Ohio physicians also made it clear that the time has come for legislation that mandates more HIV testing of patients (see sidebar "OSMA's AIDS Proposals").

"We're going to see if there is some way to incorporate the resolutions passed by this year's House into HB 419," says John Van Doorn, director of OSMA's Department of Legislation.

Officially, the OSMA has not, of this writing, taken a stand on the bill, but Van Doorn says it's unlikely, given both the public pressure of HIV testing of health-care professionals and the AMA's position, that OSMA will oppose the legislation. Still, he says, "it's something we will tinker with," especially with regard to adding language on patient testing. **OSMA**



House Bill 419: What the bill would require

- Every physician who receives a positive HIV test or is diagnosed as having AIDS would be required to notify the State Medical Board, the Ohio Department of Health and any health-care facility at which he/she is employed about his/her positive test results. If the physician is self-employed or a member of a partnership, the notification would be required to be given to every patient on whom the physician proposes to perform an invasive procedure. (Similar requirements would be applied to dentists and nurses.)
- The State Medical Board would require every physician to indicate on his/her application for licensure to practice medicine in Ohio whether he/she has received a positive HIV test. Failure to answer truthfully is grounds for revocation or denial of the physician's license.
- The State Medical Board would be required to determine how to modify the practice of an HIV-positive physician, and the physician would be required to modify his/her practice. The board would be required to adopt rules to establish how to modify the practice of a physician who tests positive for HIV.
- A physician subject to an order by the board to modify his/her practice would have the right to an appeal under Chapter 119.
- The bill would require the Ohio Department of Health to adopt rules to: 1.) define invasive procedure; and 2.) write guidelines for health-care facilities that these facilities must follow when a health-care practitioner informs them that they are HIV positive. (A health-care facility that learns that a health-care professional who performs invasive procedures has tested HIV positive shall determine which patients to inform and how to modify the professional's practice. The facility shall notify these patients, and the professional shall modify his/her practice as so ordered.) **OSMA.**

Legislation

OSMA's AIDS Proposals

The OSMA House of Delegates passed the following resolutions concerning AIDS and AIDS testing:

Substitute Resolution No. 45-91 — HIV Testing

Resolved, that the Ohio State Medical Association propose state legislation to amend Ohio Revised Code section 3701.242, to permit physicians to test patients for HIV infection as currently permitted under Ohio Revised Code for other communicable diseases, and be it further

Resolved, that the OSMA propose legislation to require HIV anonymous test sites to develop a code for identifying and notifying infected individuals who do not return for their test results.

Amended Resolution No. 46-91 — HIV Testing

Resolved, that the Ohio State Medical Association pursue state legislation that would require the medical community to treat HIV infection like other communicable diseases to include testing, reporting, tracking and contact tracing.

Resolution No. 49-91 — AIDS Resolution Regarding Individual Hospital HIV Policies.

Resolved, that the OSMA recommend legislation to provide that physicians who comply with a hospital's HIV infectious disease policy be held harmless from litigation for breach of privacy when reporting HIV-positive individuals to the appropriate infectious disease committee of the hospital; and be it further

Resolved, that the OSMA

recommend that the AMA adopt as policy that physicians who comply with a hospital's HIV infectious disease policy be held harmless from litigation for breach of privacy when reporting HIV-positive individuals to the appropriate infectious disease committee of the hospital.

Two additional AIDS resolutions dealt with expanding benefits for HIV-infected physicians. **OSMA**



Ohio may get tougher on seat belt compliance

Fasten your seat belts — Ohio may be heading for tougher enforcement of its seat belt law.

The Ohio Department of Highway Safety recently outlined a campaign to boost compliance to the law to 70% by the end of 1992. Current figures show that compliance is now close to 47% — up from a 15% compliance rate when the law first took effect in

May 1986.

Later this year, the department will launch a major study of seat belt use, with possible legislative proposals to follow. One proposal that Charles Shipley, the department's director, favors is changing violations of the law from a secondary offense to a primary one. Presently, violators are only cited if they are stopped for another offense. (Fines are \$20 for drivers, \$10 for passengers, and can be waived if motorists view a film about the advantages of using seat belts.) If violations are changed to a primary offense, officers will be permitted to make a traffic stop solely for non-compliance to the seat belt law.

Both the AMA and the OSMA have policies that support the use of seat restraints in automobiles. AMA's Substitute Resolution 133 A-85, Mandatory Seat Belt Utilization Laws, supports the laws while maintaining that such support does not relieve automobile manufacturers of their responsibility to install passive restraints. In May 1984, the OSMA House of Delegates adopted Amended Resolution 47-84, which called for the OSMA to lobby for *enforceable* legislation, mandating the use of seat belts during automobile travel in Ohio. The resolution was reaffirmed by the House the following year. **OSMA.**

Legislation

Steroid bill becomes law

State law now prohibits the sale, prescription or dispensing of anabolic steroids for anything other than lawful purposes. The laws, which originated as House Bill 62, sponsored by Rep. Suzanne Bergansky (D-Bedford) and actively supported by the OSMA, was signed into law in May by Gov. George Voinovich.

The bill also requires all athletic facilities in the state, including high school and college locker rooms and public and private gyms, to post signs warning of the dangers and health risks of using steroids for increasing strength or growth.

Violators can be charged with either a felony or misdemeanor, depending on the amount of steroids involved and whether or not there were prior convictions.

Steroids were brought under federal regulation in March, but the new state law is expected to further curb the estimated 6.6% of high school seniors and 15%-20% of college athletes who misuse the drug to boost body strength. **OSMA**

House considers Medicaid assessment

Whatever happened to House Bill 353? Officially known as the Medicaid provider assessment program, State Rep. Paul Jones (D-Ravenna) introduced it this past spring, and for awhile it appeared as though it might be passed as an add-on item to the state budget.

Basically, the bill proposes a means of supplementing the state

Medicaid budget by levying a tax on all Medicaid providers — including physicians — at a rate of 15% of the amount of Medicaid reimbursement received during the prior year. With this tax money in hand, Ohio proposes to ask the federal government to contribute a 60% federal match, which the state would then return to providers by increasing Medicaid reimbursement.

Kentucky passed almost identical legislation in February this year, and at least two other states have enhanced their Medicare budgets with similar laws.

Ohio even has such a program in place now — the hospital care assurance program, which was initiated in 1988. Under this plan, hospitals are assessed, federal Medicaid funds are collected and the combined assessment and match monies are paid to hospitals, based on the amount of indigent care that hospital provides. The law guarantees that every hospital receives back at least as much as it contributed. Under HB 353, the hospital assessment will increase.

But the concept is still “cost-shifting,” plain and simple. “Right now, the state is working with an extremely tight budget,” says John Van Doorn, director of OSMA’s Department of Legislation.

Consequently, lawmakers are exploring avenues that will somehow allow them to increase their resources without raising taxes.

HB 353 is one of those avenues, but the bill concerns OSMA for a couple of reasons.

OSMA concerns

First is the fear that physicians, already inadequately reimbursed by Medicaid, may refuse to treat Medicaid patients in the future if they are taxed now for doing so.

Craig Stafford, MD, of the Holzer Clinic in Gallipolis, eloquently brought this issue to light in testimony before the Human Resources Subcommittee of the Senate Finance Committee in June.

“The current reimbursement schedule discourages physician participation in the Medicaid program,” Dr. Stafford testified. “If the rates ever had any relation to the actual cost of providing services, they clearly do not now.”

He went on to tell the subcommittee that in order for a physician to accept any significant number of Medicaid patients, it is necessary for him or her to cover the losses that result from the artificially low payment rates. This is generally done, Dr. Stafford continued, by increasing the charges for other patients and shifting the loss to other third-party payors or private pay individuals.

Yet the first questions asked of Dr. Stafford after he completed his testimony was how much do physicians at the Holzer Clinic earn?

“The senator was trying to make the point that physicians can absorb a lower than customary reimbursement,” says Van Doorn.

A shell game

Another of OSMA’s concerns with this legislation has to do with the “shell game” that’s being played as more and more states scramble for federal Medicaid dollars. The more this occurs, Van Doorn wrote in a memo to OSMA’s physician-leaders in April, the more likely it is that the federal government will deny the match. “This year, HCFA tried to deny the match money for Ohio’s hospital care assurance programs because other states have enacted such programs,” says Van Doorn.

Legislation

Congress rescued the federal money for the Ohio hospital program for 1991. But there are no assurances that federal money will be there in 1992.

As of this writing, HB 353 still stands as both a budget item and a piece of legislation before the House. However, it has been defused for the time being.

"The Senate pulled all the language having to do with providers out of the budget amendment," says Cynthia Snyder, JD, associate director of legislation. However, that language is still subject for negotiation in a conference committee that's composed of three representatives and three senators.

"What will probably happen is that the Department of Human Services will be asked to extend the federal waivers allowing that language about providers to be included in the bill," says Snyder.

She doubts that will be accomplished before the end of the year. However, that doesn't mean HB 353 or the Medicaid assessment of providers will disappear. OSMA's activities on the issue will continue and *OHIO Medicine* will bring you news of further developments. **OSMA**

OSMA earns physicians refund from state Stabilization Reserve Fund

Thanks to OSMA's successful lobbying, physicians who contributed to the state Stabilization Reserve Fund (SRF) soon will be eligible for a refund from the state. However, each eligible physician must file a claim with the Ohio Department of Insurance within 180 days of the publication of a public notice in numerous Ohio newspapers. As of this writing, the date for publication of that notice is not certain. However, OSMA members will also be notified through OSMA publications, and OSMA will have claim forms available.

The SRF was created in the mid-'70s as a supplemental fund to pay excess medical liability claims that the state Joint Underwriting Association fund could not pay. (See the accompanying article on the history of the JUA and SRF.) All physicians who practiced in Ohio and carried medical liability insurance coverage during the years 1976-1979 were required to contribute to the SRF. These same physicians are now eligible for refunds. The amount of the refunds will vary depending upon the amount that the physician originally paid into the SRF fund, but they will include interest on the amount contributed.

In addition, this same provision in the budget created a new Ohio Medical Quality Foundation for the purpose of funding activities that will improve the quality of medical

care in Ohio. Among the possible activities to be funded are treatment for impaired practitioners, programs to improve graduate medical education, and risk management and quality assurance programs in hospitals. Any unclaimed SRF funds will be made available for the foundation's use. OSMA hopes to persuade the foundation's board to award a grant to fund OSMA's impaired practitioner program.

The OSMA commends Gov. George Voinovich, Speaker of the House Vern Riffe and Senate President Stanley J. Aronoff for their commitment to return the SRF funds to the physicians who originally contributed. OSMA also commends state Sen. Bob Ney of Barnesville, who was instrumental in arranging the refund through the budget bill.

Obviously, the OSMA's lobbying efforts played a major role in bringing about this refund of the SRF monies. This is a tangible example of how membership in OSMA directly benefits its member physicians.

The OSMA gratefully acknowledges the assistance of the following organizations in helping to secure the SRF funds: PIE Mutual Insurance Company, Physicians Insurance Company of Ohio, the Ohio Hospital Insurance Company, the Ohio Hospital Association, the Ohio Osteopathic Association and the Ohio Podiatric Medical Association.

Legislation

History of the JUA and the SRF

During the medical liability crisis of the mid-'70s when many insurers quit the market, leaving physicians without coverage, the OSMA persuaded the Ohio Legislature to reform the legal guidelines governing the conduct of malpractice suits. Passed in 1975, that reform legislation also created the state Joint Underwriting Association (JUA), a state malpractice insurance fund that offered physicians and hospitals an alternative from private insurers to obtain medical liability coverage.

At the same time, the Ohio Legislature created the state Stabilization Reserve Fund (SRF). Legislators thought the SRF was necessary to serve as a back-up fund to the JUA because they feared that the JUA funds might not be sufficient to handle potentially large claims against the JUA. Unlike the JUA from which hospitals and doctors could voluntarily purchase insurance, the SRF assessed all physicians who carried liability coverage. Those who purchased coverage from a private insurer were assessed \$250 annually by the SRF, while those who purchased coverage from the JUA were assessed an amount equal to their JUA premium up to a maximum of \$5,000 annually.

By the late '70s, the medical liability insurance marketplace had improved considerably. The improved market was partly a result of the passage of the 1975 reform law, and partly because private liability insurance became more widely available and affordable. The OSMA helped by creating the Physicians Insurance Company of Ohio (PICO) to offer members affordable liability coverage.

In this improved liability climate,

the OSMA persuaded the Ohio Legislature in 1979 to order the JUA to cease selling liability policies and to refund \$27 million to the SRF's assets to physicians and hospitals. The Legislature decided to retain \$10 million in the SRF's reserves in case of a crisis. Since that time the SRF's \$10 million reserves have grown to more than \$20 million.

The 1991 provision will refund

the remaining \$20 million in the SRF fund to physicians and hospitals. Any unclaimed funds will be transferred to the newly created Ohio Medical Quality Foundation to be used for the purpose of advancing the quality of medical care delivered to Ohioans. (See the related article on how to claim refunds for details on the Ohio Medical Quality Foundation.) OSMA

THE FACULTIES OF THE DEPARTMENTS OF PSYCHIATRY AND NEUROLOGY
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Reimbursement

Medicare picks Cleveland for its controversial cataract plan

Next year, the Health Care Financing Administration (HCFA) will introduce an experimental program in Cleveland that has the potential for changing the practice of medicine.

HCFA's plan will attempt to cut the costs of cataract surgery, a procedure the government has officially called "overpriced," by having doctors and hospitals submit competitive bids to Medicare in order to be designated a cataract surgery center.

The government's proposal has already drawn fire from the American Academy of Ophthalmologists and the Cleveland Ophthalmological Society, who filed lawsuits (with the support of both the AMA and the Ohio Ophthalmological Society) against Medicare officials in U.S. District Court this spring. Their lawsuit claims Medicare lacks the legal authority to implement the plan and adds that ophthalmologists who aren't designated by Medicare will "suffer competitive injury and lost revenues."

"Cataract surgery, of course, would only be the beginning. No aspect of health care would be immune," wrote Cleveland ophthalmologist Mirfee Ungier, MD, in a *Plain Dealer* editorial criticizing the plan. A *Plain Dealer* article later quoted O. David Solomon, MD, another Cleveland ophthalmologist, as saying: "You'll have a center for diabetes, for heart disease, for kidney disease. No one will be taking care of the whole patient."

Ophthalmologists aren't the only ones concerned with Medicare's



plan. The American Association of Retired Persons has also criticized it, wondering if the plan offers sufficient incentives for the elderly to use it. Those facilities and physicians named as "Medicare Designated Cataract Surgery Providers" would be able to waive the 20% copayment charged to Medicare patients. However, as one local AARP official points out, most Medicare beneficiaries have supplemental insurance that covers copayments, so they would not be attracted to a doctor who waived the 20% copayment.

Others are concerned that the lower prices will force physicians to cut corners and lower quality.

Yet many ophthalmologists in the area feel under pressure to submit a bid.

"I will probably make an application because I expect everyone else will apply," said

Samuel M. Salamon, MD, a Cleveland ophthalmologist, also quoted in the *Plain Dealer*.

Preliminary bid applications from doctors and hospitals were turned in May 23. Medicare anticipates the program will be in place early next year in Cuyahoga, Geauga, Lake and Medina counties. The experimental PPO project is also being tested in the Dallas-Fort Worth and Albany, New York areas. Greater Cleveland was chosen because much of the cataract surgeries performed in the area are performed at hospitals rather than at separate ambulatory surgical centers. Dr. Solomon probably sums up reaction to Medicare's selection of its test sites best: "Probably every ophthalmologist in Cleveland would agree we wish they had chosen Cincinnati to test the plan." OSMA

Reimbursement

One physician's experience with electronic claims filing

The pressure keeps mounting to file Medicare claims electronically, and more and more physicians are doing just that. Are those physicians who have made the change satisfied with the switch?

The answer to that question depends largely on whom you ask, but recently Dayton ophthalmologist Jay P. Kelman, MD described his own experiences with electronic claims filing at the Electronic Media Claims (EMC) Vendor Fair, held earlier this summer in Columbus. Nationwide-Medicare and the OSMA were two co-sponsors of the day-long event.

According to Dr. Kelman, the move away from hard copy or paper claims filing has its advantages.

"One advantage is that electronic claims filing is a good method of determining whether or not something is amiss with your claims. You'll know right away," he says.

Office group manager John Kristoff, who was on the program with Dr. Kelman, explains: "Your computer will let you know if there is any structural data that needs to be cleaned up before you send it to the carrier," he says. The carrier, too, filters for any structural defects and if any are noted, it goes right back to you. Logical screens are also applied so that any incorrect or incomplete claims are also promptly returned for correction, rather than winding their way to a claims examiner to determine the problem.

"Doing your own keying also helps to cut down on errors," says Kristoff.



Jay P. Kelman, MD

These cleaner claims, both men say, amount to fewer delays which in turn lead to faster turn-around time and quicker payment.

Still, there are some downsides to the electronic claims filing picture.

"When I first looked into this," says Dr. Kelman, "I found out that I couldn't use an asynchronous modem." Instead, Medicare insists participants use a bisynchronous modem, which, says Dr. Kelman, runs about \$1,800. "That's when I began to question whether or not I should pursue electronic billing," Dr. Kelman continues. "I sat down and calculated all the costs, and even though I knew electronic billing would save me money in the long-term, I still choked."

Medicare's Jim Cuppy explains that Medicare's decision to use bisynchronous modems was a "business decision." "They're safer than asynchronous modems," he says, "because there is no security with an asynch modem.

Others can get into these systems, and they do. That's what creates those viruses you hear about. In an asynch modem, you could transmit garbage that would make my system blow up, and I could do the same to you. The expense of a bisynch modem is greater, but we believe the protection it offers us, and you as well, is worth it," he says.

However, asynch has improved over the years, and many of these problems have been either eliminated or minimized. In fact, Medicare is in the initial stages of developing asynch capabilities. "For example," Cuppy says "Medicare can bring asynchronous modems on line and make it look bisynchronous, so that they can be brought into the system.

Another complaint Dr. Kelman has with electronic filing deals with busy Medicare phone lines.

Cuppy admits Medicare's line was chronically busy. "We process 2 1/2 million claims a month," he says. "About 800,000 to 900,000 of these come in electronically, so it wasn't unusual for Medicare's lines to be tied up." However, he says, as soon as Medicare is aware of a serious "busy signal" problem, lines are added to alleviate the situation. And Medicare has just added five modems to handle increased volume. Nevertheless, he advises that the best time to place a call to Medicare's division is from 8:00 to 9:00 a.m., from noon to 2:00 p.m. ("when everyone else is at lunch," says Cuppy), and after 4:00 p.m.

"We've increased the staff in our EMC department so we can be more responsive to calls," says Cuppy.

However, if trouble with your system arises, Medicare may not be the best entity to turn to anyway.

Dr. Kelman, Kristoff and Cuppy

Reimbursement

say that a responsive vendor is probably your best bet for dealing with problems.

"What are you going to do when Medicare changes the rules *again*?" asks Dr. Kelman. "The answer is to get a vendor who can handle that kind of thing easily."

Dr. Kelman also suggests that physicians contemplating a switch to electronic claims filing look for a system that: can stop electronic billing easily "because some claims can't go through electronically," he says; and has software configurations that allow you to enter data and set up your format electronically.

Medicare experts predict that the day is coming when the information you process through electronic filing will be sent back to your system in such a way that it will automatically post your accounts.

"Remittance feedback is also on the horizon," says Cuppy. Within a year or 18 months, it may be possible to have the money owed you electronically deposited into your account.

Cuppy also firmly believes that in the not-too-distant future, physicians can expect to be penalized in some way for not filing electronically.

"Congress believes that money can be saved by filing claims electronically, and I predict a bigger emphasis will be placed on electronic claims in the future," he says.

Penalties may not be financial. A bill, currently under consideration by the U.S. Congress would put a significant gap (about four weeks) between paying an electronic claim and a hard-copy claim.

That's the kind of time difference that may have a lot more physicians looking into



Electronic Media Claims Vendor Fair attracts physicians.

electronic claims filing in the future.

"EMC has worked in my office," says Dr. Kelman. "But assess your needs carefully. It may not be worth it if you process only

five or 10 Medicare claims a week." He concludes by saying: "If you do decide to go into it, make sure you have good software, and good support from your software vendor." **OSMA**

Switching to electronic claims filing? Before you buy that computer . . .

Interested in giving electronic claims filing a try? Jack Valancy of Management for Health Care, a consulting firm, spoke recently at the Electronic Media Claims Vendor Fair in Columbus, about obtaining a computer system. He makes the following suggestions.

"A computer is a tool for performing a task, but *you* have to decide whether or not it's your best tool," says Valancy. He warns physicians that computers can't compensate for unsound office procedures or poorly trained staffs,

and says before considering a computer system, physicians should first address any of the following accounting problems their practices may have:

- bad debts
- high accounts receivable
- inaccurate patient information
- incorrect, late or missed transactions
- undetected or uncorrected errors
- high backlogs of work in process

continued on next page

Reimbursement

- hard-to-collect delinquent accounts and
- rejected insurance claims.

"Don't let rejected insurance claim forms pile up in your office," advises Valancy. Too often, insurance forms that have been returned are set aside with the intention of "getting around to them sooner or later." "But insurance claim forms are like cockroaches. You need to deal with them as soon as they come in, or soon you'll have an infestation," Valancy says.

About software — it should:

- perform individual and family billing
- handle multiple insurance carriers
- have open item processing
- produce a clear patient bill
- offer billing options
- offer other options, like collection tools and management information reports.

Hardware requirements should include:

- adequate system speed — not too fast or too slow.
- a terminal for each operator
- telecommunications
- disk storage, preferably for 18-24 months.
- a back-up storage device
- a printer — dot matrix or laser
- an uninterruptable power supply.

When determining the total cost of the computer, factor in the following:

- costs of installation of hardware, software, training, cables and electric, data conversion, other installation costs.
- costs of ongoing support and maintenance
- costs of hardware/software maintenance
- forms and supplies
- telephone lines



Jack Valancy of Management for Health Care.

- other ongoing costs.

Add these figures and come up with an annual figure, then look at the five-year costs, which is the length most good systems will run, says Valancy. If you decide that, despite the initial start-up and ongoing costs, installing a system in your practice would be worthwhile, Valancy recommends shopping around and determining the following from your vendor *before* buying any system:

- does the vendor have a documented implementation plan? an installation checklist? The vendor should.
- do you or the vendor pick up the cost of any site preparation that will be necessary for placing the equipment?
- how many total days of

training does the vendor offer? Where will it be given (at the vendor's is best, says Valancy). Is there a full-time trainer? A documented training schedule? A user's manual that's easily understood?

- who installs the hardware/software? Who sets user-defined parameters? Who creates the tables?
- where will the software be tested? (Again, at the vendor's is best.)
- how are patient account records converted? (Balance forward arrangements are usually best.)

Make sure you understand, too, what type of post-implementation support the vendor provides:

- are there routine visits?
- how does the vendor monitor progress?
- is additional training provided?
- what type of telephone support is provided, and when is it available?

- is support by modem or provided on-site?
- does hardware maintenance include parts and labor?
- who provides the maintenance?

As far as software support, determine who provides it, the vendor or software publisher. Also:

- is there a toll-free phone line?
- unlimited phone support?
- user group meetings?
- new versions of software?

Finally, Valancy suggests you ask vendors for a list of user references. "Get some of their customers' names, and give them a call. Ask them if they're happy with the system, the types of problems they've had, and if they had to do it over, would they buy the same product? That's the best way to find out what you need to know." **OSMA.**

Reimbursement

Medicare fee schedule holds bad news for most physicians

The proposed Medicare fee payment schedule released by the federal government in June, has doctors up in arms. The proposal has no victors only losers, they say — and some have a great deal more to lose than others.

All physicians, no matter what specialty, no matter where they are in the country, will be affected (see chart).

Over the next five years these proposed rules, if implemented, would replace the current charge-based Medicare payment system with one that uses the Resource-Based Relative Value Scale (RBRVS) to determine reimbursement levels.

“Physicians feel the method of implementation that has been chosen by HCFA (Health Care Financing Administration) has violated the physician’s trust, has misunderstood the will of Congress, and, if allowed to stand, will do irreparable damage to physicians’ ability to care for their patients,” says James E. Todd, MD, AMA executive vice president at a Washington, D.C., news briefing recently.

OSMA is urging physicians to write their U.S. senators and representatives to express their outrage at these proposed rules. Congressional intervention might be the only way to prevent the devastating 16% reduction in the RBRVS conversion factor that is being called for. The 16% cut goes way beyond the promised budget neutrality and threatens to undermine physician payment reform before it is implemented, according to Deborah Bahnsen, JD, Department of Professional Relations and Ombudsman Services.

Impact of 1992 & 1996 RBRVS implementation by specialty

Specialty	% change from 1991*	
	1992	1996
• All physicians	– 3	– 16
• Anesthesiologists	– 8	– 35
• Cardiologists	– 5	– 17
• Chiropractors	– 8	– 14
• Dermatologists	– 2	– 15
• Family physicians	13	15
• Gastroenterologists	– 7	– 25
• General practitioners	14	14
• General surgeon	– 5	– 20
• Internists	0	– 3
• Nephrologists	– 4	– 15
• Neurologists	– 4	– 9
• Neurosurgeons	– 6	– 25
• Ophthalmologists	– 8	– 35
• Optometrists	13	12
• Orthopedic surgeons	– 6	– 19
• Otolaryngologists	2	– 4
• Pathologists	– 6	– 30
• Plastic surgeons	– 6	– 17
• Podiatrists	5	16
• Pulmonologists	– 4	– 8
• Psychiatrists	– 9	– 5
• Radiologists	– 6	– 32
• Thoracic surgeons	– 7	– 31
• Urologists	– 4	– 15

Source: Health Care Financing Administration

* Figures may vary by geographic location.

RBRVS appeared to be a beacon in the dark during the mid-’80s when Medicare’s “customary, prevailing and reasonable” (CPR) payment process was all over the place. The intention of the new system is to replace the CPR with a standardized reimbursement schedule for each procedure, no matter which type of specialist performs it. Although the OSMA and American Medical Association supported the concept of an RBRVS, both groups are very disappointed with the proposed rules. Ohio physicians and others throughout the country feel they

have been betrayed. Physicians originally supported payment reform because they felt it would be implemented in a fair and reasonable manner and not be used to slash the budget.

Because of the magnitude of its impact and because it affects all specialties in the country, the conversion factor must be the number one priority for medicine.

There are three elements to the conversion factor:

1. The Notice of Proposed Rule Making (NPRM) includes a “behavioral (volume) offset”

continued on page 395

Reynolds' Illness and Autopsy

THE ILL-SIGHTED

PORTRAIT PAINTER

By James G. Ravin, MD



Sir Joshua Reynolds (1723-1792) was the most respected painter in England during the late 18th century. He was knighted by King George III and was the first president of the Royal Academy. Admired as a portrait painter, his services were in great demand, and he ran a large studio with many assistants and pupils. Reynolds was a good friend to many of the important figures

in medicine, politics, literature and the theater, and often painted

their portraits.

Master Henry Hoare's portrait of 1788, illustrated on the cover, is an elegant depiction of a child.¹ His long blond curls, his dress with a ribbon, and his fancy hat are certainly not the way a male child would be dressed today, 200 years after this painting was created. Children, whether boys or girls, were dressed similarly at the time. We can easily appreciate the grace and charm of this fashionable portrait of the son of a wealthy banker. Portrait painting was very popular at the time, 50 years before the invention of photography.

Of even more interest to physicians today is Reynolds' medical history. He was born into an educated family. His father was a schoolmaster who could not afford to send Joshua to a university. Later, Sir Joshua was proud to receive an honorary degree conferred by Oxford in 1773. As with the rest of his family, Joshua learned to draw and paint. At an early age Joshua intended to practice medicine, and his father, who was knowledgeable in science, helped educate him. The boy was to be apprenticed to an apothecary (general practitioner) in Plymouth. He told his father he would rather be an

Art and Culture

apothecary than an ordinary painter, but if he could be taught by an eminent painter, he would prefer to become an artist. Instead of studying medicine, he studied with a distinguished artist, then traveled to Italy to study the old masters. While on the continent he developed a severe middle ear infection that left him with a severe hearing loss for the rest of his life. Some critics have felt the loss of hearing enhanced his visual perception.

In 1782, at age 59, he suffered a mild stroke, but soon recovered.² A greater problem occurred in 1789, and caused him to abandon a very successful career. This was the sudden onset of vision loss in his left eye. He described a dimness of vision, as if a curtain were drawn over his eye. His doctors diagnosed "gutta serena," an antiquated term meaning loss of vision with the pupillary space retaining its normal clarity. Since the ophthalmoscope had not yet been invented, the interior of the eye could not be examined. From his description, he may well have had a retinal detachment. Two years after the onset of visual loss, swelling and pain occurred, possibly due to a secondary glaucoma. His surgeon bled him with leeches, purged and blistered him, without relief of his symptoms. Reynolds became depressed and lost weight from anorexia. The following year, just 10 days before his death, two physicians examined him and discovered enlargement of his liver. He was treated with mercury, but soon died.

John Hunter, the famous surgeon and anatomist, was one of three men who autopsied the body. (Reynolds had painted Hunter's portrait seven years earlier). The post mortem report states "In the cavity of the belly the only diseased part was the liver which was of a magnitude very uncommon, and at least double of what is natural: it weighed 11 pounds, and was of a consistency

which is usually called scirrhus. It had lost its natural color and become of a pale yellow. We found the optic nerve of the right side shrunk and softer than natural. There was more water in the ventricles of the brain than what is generally found at so advanced an age."³

In retrospect, the combination of sudden visual loss, presumably due to a retinal detachment, followed by death two years later, with a massively enlarged, abnormal liver, is most compatible with the diagnosis of malignant melanoma of the eye metastatic to the liver.^{4,5} **OSMA**

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James G. Ravin, MD, Toledo, is chair of the Art and Culture Committee and a member of OHIO Medicine's Advisory Board.

Speaking Out on RBRVS . . . continued

despite the fact that HCFA's own research failed to demonstrate the need for such an offset. The Medicare Volume Performance Standard (MVPS) is currently being used to adjust physician payments as a result of volume increases. Applying a behavioral offset would be redundant.

2. HCFA maintains that any adjustments in physician payment to maintain budget neutrality must be applied just to the conversion factor. This creates a "tripling effect." For every 1% adjustment, the conversion factor must be reduced by 3% because in 1992 the conversion factor represents only one-third of the total Medicare payment. The tripling effect can be addressed by amending the statute to require that any adjustments be applied to the historical payment as well as the conversion factor.

3. Ambiguity in the 1992 transition formula have produced estimates by HCFA that the conversion factor must be reduced to maintain budget neutrality. This

problem is due in large part to the fact that payments for services being increased will change at a rate faster than for services to be reduced (asymmetry). This was the result of efforts to minimize the impact on those whose services would be reduced and to accelerate the increases for primary care services. The unintended effect is to produce a reduction in the conversion factor.

The AMA has produced an analysis of the NPRM for distribution, which is currently available through the OSMA Department of Ombudsman Services. This analysis will assist physicians in structuring comments to HCFA on the cuts in the conversion factor as well as other portions of the NPRM. Comments on the NPRM, (which must reach HCFA by August 5) should be mailed to: Health Care Financing Administration, Department of Health and Human Services, Attention: BPD-712-P, P.O. Box 26686, Baltimore, MD 21207. **OSMA**

Science and Education

Mahoning County provides health education for fair visitors

This is the time of year when Ohioans pack themselves onto fairgrounds to see the latest in agricultural developments, but each year visitors to the Canfield Fair — the largest county fair in the U.S. — receive a little health education as well.

Since 1946, the Mahoning County Medical Society has coordinated and planned a health-care exhibit that is displayed in the permanent "Health and Medical" building on the Canfield fairgrounds. Generally, over 30 exhibits instruct visitors about various aspects of their health, and volunteer physicians from the Mahoning County Medical Society are on hand to answer specific medical questions.

Jack Schreiber, MD, chair of last year's Canfield Fair Committee, estimates that 200,000 people pass through the building during the five-day fair.

Anyone interested in organizing a similar exhibit for their local county fair should contact the Mahoning County Medical Society, 5104 Market Street, Youngstown, OH 44512, (216) 788-4700, for advice. If you are just interested in attending the Canfield Fair to see the Mahoning County Medical Society exhibit, fair dates this year are August 30 through September 3. **OSMA.**



Science and Education

Bone development questions to be answered in Cincy

Can environmental influences experienced early in life affect bone development in later life? Are there racial differences in bone mineral development? What effects does exercise have on bone development in infancy?

Researchers at Cincinnati Children's Hospital Medical Center are attempting to learn the answers to these questions, and more, in a four-year study funded by a grant from the National Institutes of Health.

The study will follow a random sample of 96 infants (half black, half white) from three to 18 months of age, at several child care centers in the Cincinnati area. One group of 48 infants will engage in large muscle exercises, while the other group of 48 will be trained in fine motor/cognitive exercises. These exercises will be administered to infants from six to 18 months, five days a week, 15 minutes per child. The infants will be given total body scans every three months to allow researchers to track each infant's progress, and to keep an accurate record of any racial or exercise developments in bone mineral development. **OSMA.**

Researchers say silica, not coal, to blame in black lung disease

Across the border in West Virginia, researchers have determined that particles of silica and not coal dust are to blame for the suffocating black lung disease.

"When you think about it, there's really no reason for coal to be toxic," says Knox Van Dyke, a

professor of pharmacology and toxicology at West Virginia University who has studied the issue for 15 years. "Coal is carbon, and humans are made up mostly of carbon and water."

Van Dyke and a co-investigator found that silica particles bind with calcium in the lung cells, killing them or causing inflammation. Coal dust, on the

other hand, poses little risk, says Van Dyke.

"Any kind of dust can cause mild inflammation, but only silica dust has this kind of long-lasting toxic effects," he says. Then he adds: "Coal dust will turn your lungs black, but without the silica, I believe you won't get black lung disease." **OSMA.**

No deer tick, no Lyme Disease? Not necessarily so, say health officials

Support groups for victims of Lyme Disease are beginning to form in southwest Ohio, yet health officials are still unclear as to exactly how widespread the problem is across the state and what is causing the disease.

Since Lyme Disease did not become a reportable disease until June 30, 1990, cases reported *before* this date were made on a voluntary basis and probably represent only a portion of the total number of existing cases. Balancing this, however, is the fact that not all of the cases turned into the Ohio Department of Health prove to be actual cases of the disease. In 1989, for example, only 69 out of 98 reported cases were determined to be the real thing.

Nevertheless, cases do appear to be increasing across the state. Last year, 113 cases of Lyme Disease were reported to the ODH and, as of May, this year, 34 new cases have been added to the total.

Mysteriously, however, Ohio remains relatively free of the deer tick that causes the disease. The deer tick is not common in Ohio, and only three have been found in the state since reporting began

(Butler County, 1989; Clermont County, 1990; and Williams County, 1990). None of the deer ticks found in Ohio was infected.

Usually, a Lyme Disease infection in an Ohio victim is explained by his or her travel to states such as Wisconsin and Minnesota where the deer tick is common. However, since about half of the people in Ohio who report having the disease say they haven't traveled outside the state, health officials are now beginning to wonder if the deer tick is the only vector transmitting the disease. There may be a possibility that it's being spread some other way in the state, possibly through other ticks or blood-sucking insects. Until the matter can be resolved, health officials are urging those who enjoy the outdoors to use caution before heading into tall grass or wooded areas. **OSMA.**

(Next month, *OHIO Medicine* will feature a report prepared for physicians by the Ohio Department of Health on arthropod-borne diseases. Lyme Disease is included in the report.)

HIV prevalence in childbearing women Ohio, 1989-1990

The Ohio Department of Health cooperates in an ongoing national project coordinated by the Centers for Disease Control to assess levels and trends of HIV infection in childbearing women. In this study, heel stick blood specimens from newborns submitted for metabolic screening are tested for HIV antibodies. Because antibodies in newborns are a sign of maternal infection, the results provide an accurate estimate of the number of HIV-infected women giving birth over a specified period. Before HIV testing, all links to individuals are removed; thus, this is a blinded survey. In no way can the results be traced back to the mother or newborn.

In both 1989 and 1990, newborn specimens sent to the state public health laboratory were screened for six months. In each year, over 90% of the eligible specimens were tested for antibodies to HIV. In 1989, the Ohio seropositivity rate was 0.44 per 1,000 (73,254 specimens tested). In 1990, 80,494 specimens were tested with a confirmed positive rate of 0.51 per 1,000. Assuming no seasonal variation in the HIV prevalence, the seroprevalence rate found in each survey can be applied to the total number of mothers giving birth in that year. Out of an approximate 159,600 women delivering in Ohio in 1989, we estimate 70 were HIV seropositive. In 1990, there were approximately 83 HIV-infected mothers out of a provisional total of 163,550 women giving birth. Figure 1. illustrates the survey documented distribution across Ohio of HIV-infected women according to the ZIP code of the hospital submitting the

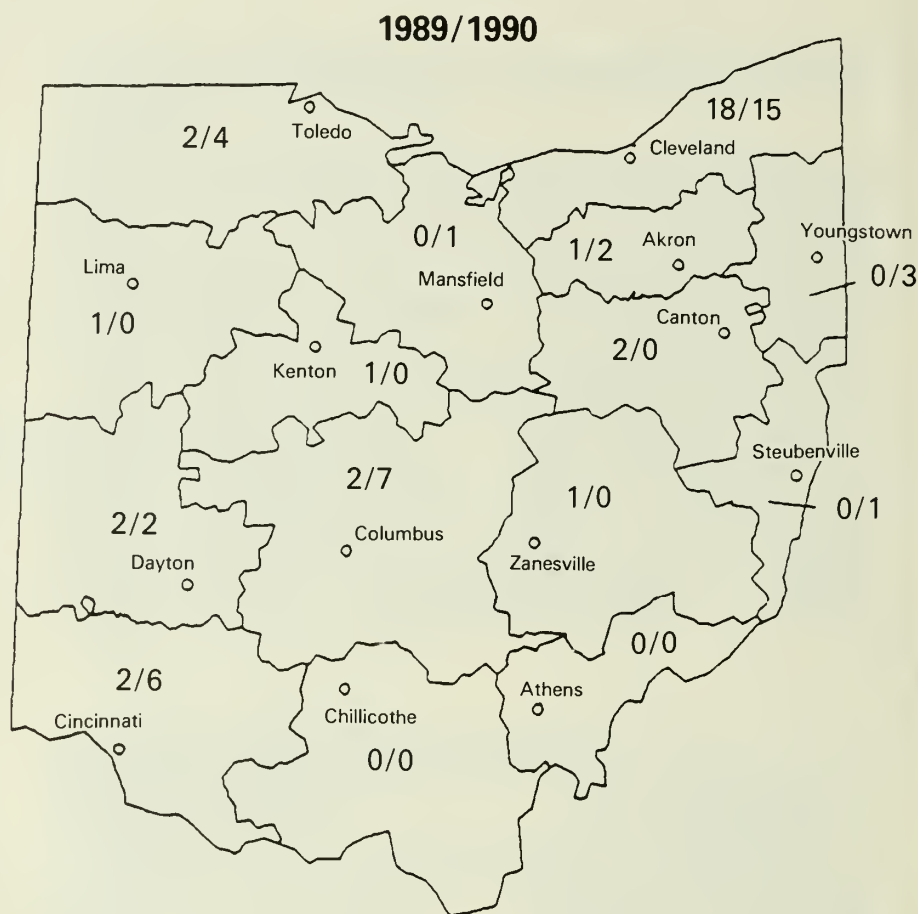


FIGURE 1. Location of seropositive mothers based on the hospital submitting the newborn screening specimen in the 1989 and 1990 surveys.

newborn specimen.

Blinded studies are particularly valuable in following trends over time. Increases in HIV positivity among childbearing women can serve to warn of an expanding epidemic. Rapid expansion is not evident at this point in time; that is, the 1990 rate does not represent a statistically significant increase over the 1989 rate.

Ohio's 1990 seropositivity rate is in the middle range among states participating in this national study. It is substantially lower than rates recorded in states such as New York, New Jersey and Florida.

Ohio's rate is similar to that in Arizona, Colorado and Maine. Other states involved in the study for two consecutive years have also observed no dramatic increases in HIV seropositivity among childbearing women.

The precise risk of perinatally acquired HIV infection for infants born to HIV-infected women is currently a matter of debate, with data from Europe suggesting this risk is under 20%. However, the best accepted risk estimate in the U.S. is that approximately 30% of infants born to HIV-infected women are infected during the

Science and Education

perinatal period. Using the latter risk figure and the above estimates of infected women giving birth, Ohio data predict that 21 infected infants were born in 1989 and 25 in 1990. The figures should be of use to clinicians and others planning for the needs of such children.

While any level of HIV infection in childbearing women is cause for concern, the levels observed in Ohio are, in absolute terms, low. This fact has special implications for clinical practice. Because HIV tests, even in combination, are not perfectly accurate, screening in a population with a HIV seroprevalence of 4-5 per 10,000 can be expected to produce a significant false positive rate. This is of minimal importance in a blinded study, but it can be a major problem in interpreting a positive result in a particular woman. With optimal laboratory performance that achieves the accuracy specified by the manufacturers of commercially available HIV tests, about one confirmed positive test in 10 performed on childbearing women in Ohio could be expected to be a false positive. Even minor departures from optimal test performance, such as have been documented in proficiency testing, can increase the false positive rate significantly. If nonblinded (linked) HIV testing is performed on members of the general population of childbearing women in Ohio without regard to their risk history, the results should be interpreted with caution. It deserves note that when a woman reports risk behavior, multistage testing achieves very high predictive values. **OSMA**

Clinical Clips

95%

Percentage of the 60 million people with hypertension who have a genetic predisposition

50,223

Number of new cases of syphilis in 1990

156

Number of black men per 100,000 with syphilis

116

Number of black women per 100,000 with syphilis

3

Number of white men per 100,000 with syphilis

2

Number of white women per 100,000 with syphilis

8,500

Number of infants weighing less than 1.6 pounds born in U.S. each year

\$2.6 billion

Amount spent nationally on neonatal care each year

200,000

Number of infants treated annually in the more than 500 neonatal intensive care units nationally

8 to 10 million

Number of people who have been infected with AIDS virus worldwide during the 1980s

30 million

Number expected to be infected by AIDS in 1990s

70%

Percentage of prostitutes in Bombay, India who are infected

70

Number of AIDS cases reported in Thailand but there are an estimated 250,000 infected

6% to 13%

Percentage of infants in the U.S. exposed to cocaine before birth

100,000 to 375,000

Number of drug-exposed babies born in U.S. in 1989

Sources on page 420

Obituaries

NICOLAS BALMORIA, MD, Greenup, KY; College of Medicine Manila Central University, Manila, Philippines, 1953; age 65; died May 7, 1991; member OSMA.

CLIFFORD C. BOWEN, MD, Cincinnati; University of Michigan Medical School, Ann Arbor, MI, 1953; age 61; died May 18, 1991; member OSMA.

SIDNEY M. COPELAND, MD, Dayton; Tulane University School of Medicine, New Orleans, LA, 1929; age 84; died June 3, 1991; member OSMA and AMA.

NECDET EMIR, MD, North Olmsted; Bursa Tip Fakultesi,

Istanbul Universitesi, Bursa, Turkey, 1951; age 66; died May 29, 1991; member OSMA.

WILLIAM J. KENNEDY, MD, Granville; Ohio State University College of Medicine, 1952; age 65; died June 4, 1991; member OSMA.

HARRY E. KING, MD, Worthington; Case Western Reserve University School of Medicine, 1936; age 81; died June 10, 1991; member OSMA and AMA.

CHARLES R. LULENSKI, MD, Aurora; University of Michigan College of Medicine, Ann Arbor, MI, 1936; age 78; died May 8, 1991; member OSMA and AMA.

PAUL J. MAHAR, SR., MD, Canfield; Ohio State University College of Medicine, 1933; age 86; died June 3, 1991; member OSMA and AMA.

ANNE S. MASTER, MD, Cleveland; Medical College of Pennsylvania, Philadelphia, PA, 1938; age 81; died May 11, 1991; member OSMA and AMA.

CHARLES J. MCGAFF, MD, Pompano Beach, FL; University of Louisville School of Medicine, Louisville, KY, 1953; age 63; died May 13, 1991; member OSMA and AMA.

Ohio Medi-scene

Philippine relief effort

The Association of Philippine Physicians in Ohio donated \$10,000 for medical supplies for victims of the Mount Pinatubo volcano eruptions. The association's 220 doctors from Cleveland and Northeast Ohio also voted to assess each member \$100 for the relief work. The \$10,000 donation came from the organization's general fund. Anyone wishing to contribute to the association's relief efforts should contact: Association of Philippine Physicians in Ohio, 5162 Broadway, Cleveland, OH. 44127.

Psychiatrist pickets prison

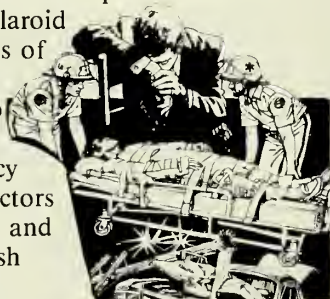
Richard Scarnati, MD, psychiatrist at Lebanon Correctional Institute, launched a one-man strike against the Ohio Department of Mental Health last June, claiming he could no longer properly treat inmates after the department eliminated a

full-time psychiatrist and two part-time assistants, leaving him the only mental health professional responsible for the mental well-being of 2,000-plus inmates. Dr. Scarnati said he would stay on strike until the psychiatric staff is boosted to ease his case load of 188 patients. When this appeared unlikely, he resigned.

Picture this

Fairfield Township Emergency Medical Services personnel are using Polaroid snapshots of accident scenes to help emergency room doctors diagnose and treat crash victims.

The photos will provide an exact record of how cars were positioned, and what damage resulted so doctors can tell by looking at the car interior precisely how the body may have impacted with the steering wheel



and other parts of the car. The pictures are taken after the victim is removed from the car, and by a member of the fire company that also responds to accidents. Life squad members do not take photographs nor transport of the victim. The cameras were presented to the squads by township trustees.

Parity for substance abusers

The Ohio Department of Alcohol and Drug Addiction Services has set aside monies from a federal block grant to be used for women-oriented alcohol and chemical abuse programs. With these funds, Ohio is working to balance the disparity of treatment and prevention services, as well as providing a continuum of care for chemically dependent and substance-abusing women. Lt. Gov. Michael DeWine says the dollars will allow for innovative programs, especially those which serve pregnant women and women with dependent children.

Prescription Precautions

AVOID THE PITFALLS

AND REDUCE LIABILITY

Does this scenario sound familiar? You're in the hospital making rounds and you meet a patient you've known and treated for years. After the usual exchange of pleasantries, she tells you: "Oh, doctor, I've got this terrible cold (rash, headache,

back pain, etc). Do you think you could give me a prescription for something? I've been too busy to make an appointment to see you in the office." Sometimes, the request is not even for the patient themselves,

but for a child or spouse. You whip out a prescription pad and write an appropriate prescription. Remedy in hand, the patient thanks you as she heads for the pharmacy, and you go on with your rounds.

There's nothing unique about this incident. The same scene is probably replayed daily in

hospitals, restaurants, stores, supermarkets and anywhere else in the community. A somewhat risky practice from a medical standpoint, "corridor prescribing" is also a bad habit to adopt from a medical-legal point of view.

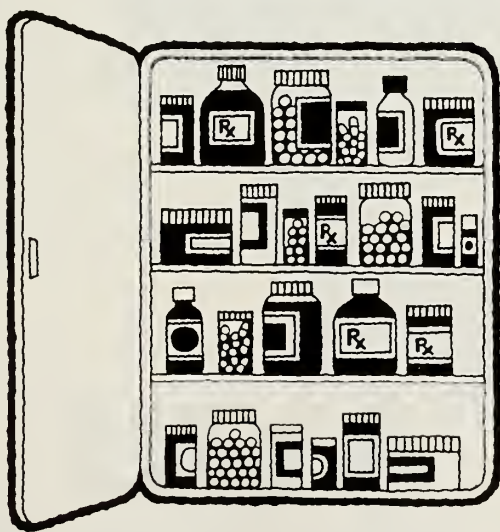
Prescribing without benefit of a physical exam, often without knowing the patient's history — or in cases involving requests for other family members, not even knowing the patient — is potentially legally dangerous for the physician and medically dangerous for the patient. Additionally, these hallway prescriptions may rarely be documented. Coupled with several minor distractions in the busy daily routine of a physician, the incident is soon out-of-mind, unrecorded and forgotten.

Negligent drug therapy is a commonly seen allegation in medical malpractice claims. Prescribing as described above only adds to the inherent risks of drug therapy. Cases have been seen in which the "hallway prescription" resulted in an adverse side effect or reaction and the patient has sued the physician for negligent prescribing. At that point in time, the physician involved has no record of the prescription and probably no recollection of the incident to aid his or her defense.

Other Prescription Pitfalls

A physician may also incur liability by repeatedly prescribing a

continued on page 403



For excellent response in the treatment of
duodenal ulcers...

AXID^(R) nizatidine

has the right answers

- Rapid epigastric pain relief^{1,2*}
- Fast and effective ulcer healing^{2,3,4}



AXID
PASSES THE ACID TEST

*Most patients experience pain relief with the first dose.
See adjacent page for references and brief summary
of prescribing information.

NZ 2943 B-149347

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AXID[®] (nizatidine capsules)

Brief Summary. Consult the package insert for complete prescribing information.
Indications and Usage: 1 Active duodenal ulcer—for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2 Maintenance therapy—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

Contraindications: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2 Dosage should be reduced in patients with moderate to severe renal insufficiency.

3 In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 35 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGPT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of androgenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumentary—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage—Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP
(091190)

References

1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol* 1987;22(suppl 136):61-70.
3. *Scand J Gastroenterol* 1987;22(suppl 136):47-55.
4. *Am J Gastroenterol* 1989;84:769-774.

NZ-2943-B-149347

Additional information available to the profession on request



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Loss Awareness

drug or by authorizing repeated refills. Liability may result when a physician prescribes a contraindicated drug or when a physician prescribes a drug without informing the patient of significant side effects.

Mismedication of the elderly is a growing liability concern. Patients over the age of 65 consume 30% of the prescription drugs and 40% of the nonprescription drugs dispensed. Although people over the age of 60 comprise roughly 17% of the population, they account for 39% of all the hospitalizations and 51% of deaths resulting from drug reactions.

The following recommendations can assist physicians and other health professionals to reduce the potential for patient injury and to lower the risk of being sued.

- Take a complete history for each patient. Ask about over-the-counter drugs. Document the patient's inability to identify drug names or dosages.
- Ask the names of all physicians the patient sees and the reasons. Such questioning may uncover additional medication used that the patient overlooked.
- Periodically ask about and document patient allergies and drug intolerance. Attach a brightly colored alert to chart covers to call attention to the allergy information.
- Carefully monitor prescriptions and refills. Do not permit office staff members to administer or refill medications without a physician's specific approval.
- Open-ended or "refill as needed" prescriptions should be avoided, and prescriptions should clearly state the number of refills authorized.
- Be familiar with indications and contraindications for drugs prescribed, dispensed or

administered, and know the signs of common side effects of drugs the patient takes.

- Patients on drugs with potentially serious side effects, as a result of prolonged use, should undergo appropriate monitoring of blood levels or clinical values to ascertain the onset of adverse reactions.
- Write clear instructions for prescription labels.
- Dispense written information and instructions for medication use.
- Include periodic pharmacology reviews and drug utilization evaluations in your quality assurance program.
- Encourage patients to ask questions about prescribed drugs. Ensure that the patient understands the drug's purpose, side effects and contraindications.
- Serious side effects of a drug regimen should be fully discussed with a patient before therapy, and informed consent should be obtained.
- Adhere to manufacturers' recommendations and guidelines or be prepared to justify your reasons for deviating from the recommendations.
- Pay special attention to prescribing drugs with an addictive potential.

The Loss Awareness Bulletin is provided each month through the OSMA Task Force on Professional Liability and its subcommittee on Loss Awareness with the assistance of the Physicians Insurance Company of Ohio.

The 1991 Annual Meeting Proceedings

Minutes of the First Session

The first session of the House of Delegates of the Ohio State Medical Association was convened at 6:12 p.m. Friday, May 17, 1991 in the Regency Ballroom of the Hyatt Regency Hotel in Columbus. John A. Devany, MD, OSMA President, called the House to order.

Dr. Devany led the Pledge of Allegiance to the flag, then called on David A. Barr, MD, past OSMA Treasurer, to lead the invocation. Ronald E. Kendrick, MD, President of the Academy of Medicine of Columbus and Franklin County, welcomed the delegates, alternate delegates and guests to Ohio's capital city, "home of the Buckeyes, Wendy's, Borden's, the Limited and OSMA's President-Elect Joseph Sudimack, MD. He invited all in attendance to a reception, sponsored by Physicians Health Plan, following the close of the First Session.

Members of the speakers table were then introduced to the House by Dr. Devany. Those seated at the table were as follows: John F. Kroner, Jr., MD, Athens, Secretary-Treasurer; William J. Marshall, MD, Dayton, Immediate Past President; D. Brent Mulgrew, JD, Managing Director; Herbert E. Gillen, Executive Director; Joseph Sudimack, Jr., MD, Columbus, President-Elect; David A. Barr, MD, Lima, Invocation Speaker; and Ronald E. Kendrick, MD, Columbus, President, Academy of Medicine of Columbus and Franklin County.

Report of the Credentials Committee

Janet K. Bixel, MD, Columbus, Credentials Committee chair, reported that of 249 delegates eligible to be seated and vote, 178 were registered and present at the First Session.

1990 Minutes Approved

The minutes of the 1990 session of the House of Delegates, as published in the July 1991 issue of *OHIO Medicine* were approved by official action.

Introduction of Out-of-State Guests

Dr. Devany introduced guests from the following out-of-state medical associations: Robert M. Reardon, MD, Bloomington, Illinois, President-Elect, Illinois State Medical Society and Mrs. Reardon; and Michael Mellinger, MD, Lagrange, Indiana, President, Indiana State Medical Association and Mrs. Mellinger. Later in the session, Dr. Devany introduced Paul Markowski, Field Representative from the American Medical Association.

Introduction of OSMA Past Presidents

At this time, the following Past Presidents of the OSMA were introduced by Dr. Devany: Robert N. Smith, MD, Toledo; Oscar W. Clarke, MD, Gallipolis; James L. Henry, MD, Grove City; John J. Gaughan, MD, Cleveland; Thomas W. Morgan, MD, Gallipolis; S. Baird Pfahl, Jr., MD, Sandusky; A. Burton Payne, MD, Ironton; Herman I. Abromowitz, MD, Dayton; John E. Albers, MD, Cincinnati; D. Ross Irons, MD, Bellevue; Donavin A. Baumgartner, Jr., MD, Cleveland; and William J. Marshall, MD, Dayton.

Introduction of Past Members of the OSMA Council

Past members of the OSMA Council were then introduced to the House by Dr. Marshall. Those in attendance were: David A. Barr, MD, Lima; Theodore J. Castele, MD, Cleveland;

William Dorner, Jr., MD, Akron; Joseph L. Kloss, MD, Akron; Henry G. Krueger, MD, Cleveland; W.J. Lewis, MD, Dayton; and Stanley J. Lucas, MD, Cincinnati.

Introduction of Past Member of the Ohio Delegation to the AMA

Dr. Devany then introduced Jack Schreiber, MD, Cleveland, who had served as a member of the Ohio Delegation to the AMA from 1969-1986.

Membership Outreach Program

At this time, Dr. Devany introduced those OSMA members who had participated successfully in the 1990 OSMA Membership Outreach Program. Each member named was to receive an OSMA watch as a token of appreciation, and was eligible for a drawing for a weekend trip to the Greenbriar Resort. Dr. Joseph Sudimack selected the winning ticket. The winner was Owen Johnson, MD, Columbus.

OMPAC Report

Dr. Devany introduced Jerome Kimmelman, MD, Toledo, board chair of OMPAC, who reported that, for the fourth year in a row, OMPAC received the AMA's AMPAC Membership award for growth in total membership, but that today's health-care climate made more physician participation necessary. He told the House that each delegate has the responsibility to return to his or her district and urge membership so that OMPAC can continue to support those politicians who help listen to medicine's opinions.

Report of the Immediate Past President of the OSMA Auxiliary

Dr. Devany introduced Mrs. Sue

The 1991 Annual Meeting Proceedings

Massie, Ironton, who was escorted to the rostrum by A. Burton Payne, MD. Mrs. Massie outlined for the House all of the projects that the state auxiliary, as well as many of the local auxiliaries, had undertaken this year. They included the auxiliary leadership day, AMA-ERF fund-raising efforts, the Day at the Legislature, a new membership brochure, and a state-of-the-art tanning brochure geared to educating young people about the dangers of tanning. Despite these efforts, however, Mrs. Massie said that not all of the problems were solved, that many challenges remained, and that auxiliaries would continue working with their physician-spouses to accomplish that which still needed to be done.

Presentation of AMA-ERF Checks

Following her address to the House, Mrs. Massie and Dr. Devany presented checks to the representatives of the following Ohio medical schools: Case Western Reserve University School of Medicine, Cleveland; the Ohio State University College of Medicine, Columbus; the University of Cincinnati College of Medicine, the Medical College of Ohio at Toledo; the Northeastern Ohio Universities College of Medicine, Rootstown; and Wright State University School of Medicine, Dayton. This year's contributions to Ohio's six medical schools from AMA-ERF totaled \$88,302.42.

Presentation of Plaques to Retiring Members of OSMA Council

The following retiring members of OSMA Council then received plaques in appreciation for their service: William J. Marshall, MD, Dayton; Stanley J. Lucas, MD, Cincinnati; and Larry Frick, Cincinnati. Louis A. Cannon, MD, Cincinnati and Edmund W. Jones, MD, Cincinnati also received plaques as retiring members of Council, although they were not present to receive them.

Presentation of Plaque to Retiring

Member of the Ohio Delegation to the AMA

Dr. Devany then presented a plaque to D. Ross Irons, MD, Bellevue, who has retired as an Alternate Delegate of the Ohio Delegation to the AMA.

Presentation of Medical Student Writing Contest Winner

At this time, Dr. Devany presented Melissa Brokaw, a third-year medical student at Northeastern Ohio Universities College of Medicine, with *OHIO Medicine's* Medical Student Writing Contest award. Her paper, "A Biopsychosocial Profile of the Geriatric Population Who Frequently Visit the Emergency Department" was judged the best entry by Richard Vilter, MD, of the University of Cincinnati College of Medicine and Richard Leighton, MD, of the Medical College of Ohio at Toledo who served as the judges. Her winning entry will appear in a future issue of *OHIO Medicine*.

Reference Committee Chairs Announced

The following House of Delegates Reference Committee chairs were announced by Dr. Devany: Credentials of Delegates — Janet K. Bixel, MD, Franklin County; Tellers and Judges of Election — Leslie E. Whitmire, MD, Lucas County; Resolutions Committee No. 1 — David Utlak, MD, Stark County; Resolutions Committee No. 2 — Donna A. Woodson, MD, Lucas County; Resolutions Committee No. 3 — Mary Jo Welker, MD, Franklin County; and Resolutions Committee No. 4 — William H. Kose, MD, Hancock County.

Election of Committee on Nominations

The House of Delegates nominated and elected the following persons, pursuant to the OSMA Bylaws, one from each district, for the Committee on Nominations: First District — Lee J. Vesper, MD; Second District — Jerry L. Hammon, MD; Third District — Susan L. Hubbell, MD; Fourth

District — Alcuin D. Bennett, MD; Fifth District — John J. Gaughan, MD; Sixth District — Brian S. Gordon, MD; Seventh District — Walter A. Jones, MD; Eighth District — John E. Lloyd, MD; Ninth District — Jack Borders, MD; Tenth District — Paul Metzger, MD; Eleventh District — William L. Hassler, MD; and Twelfth District — Michael Seider, MD. Under the system approved by the House of Delegates in 1963, the chair of the committee this year was the delegate from the Sixth District, Brian S. Gordon, MD.

Dr. Devany then asked the House to direct the Nomination Committee regarding election matters, including the number of AMA delegates and alternate delegates to be elected. The House approved the request.

President's Address

Herbert E. Gillen, Executive Director, OSMA, introduced John A. Devany, MD, to the House. Dr. Devany then proceeded to give his Presidential Address.

In his address, Dr. Devany spoke on what he considered to be the most important health care event of the past year — the establishment of a special Select Committee on Health Care Reform. Dr. Devany said that the importance of this committee cannot be overstated, and he explained that it was created to study the seven pieces of pending state legislation that touched on some aspect of health care cost and access. The most important piece of pending legislation, Dr. Devany continued, is House Bill 175, which calls for a universal health care system in Ohio. He pointed out that, if one lesson had been reinforced during the year, it was that politics is not a spectator sport. He said he couldn't emphasize enough the importance of personal contact in influencing legislators.

However, Dr. Devany also said that it's time to reach out to other groups — business people, manufacturers, other medical associations, insurance companies and review organizations —

The 1991 Annual Meeting Proceedings

for help, adding that one organization or one segment of society cannot resolve the health-care crisis on its own.

Dr. Devany predicted that reimbursement will be the most pressing issue in the future, and that, by determining what procedures are reimbursed, third-party payors cannot only control costs but, in reality, dictate how physicians practice medicine. However, he added that physicians still have significant ability to affect the future, and that there is abundant talent to do so. He concluded by urging those in attendance to go about the business of making a difference.

Special Order of Business

At this time, Dr. Devany presented a resolution that commemorated the men and women of the OSMA who served in Operation Desert Shield and in Operation Desert Storm.

Four memorial resolutions were then presented to the House, each recognizing OSMA members and leaders who had died over the past year. They included: Frank H. Mayfield, MD, Cincinnati; Edwin H. Artman, MD, formerly Chillicothe; John Peter Minton, MD, Columbus; and William Havener, MD, Columbus.

Dr. Devany then recognized Jerry Campbell of the OSMA staff for 25 years of outstanding service to the physicians of Ohio. He presented him with a plaque, and the House recognized his service with a standing ovation.

Introduction of Resolutions

Dr. Devany announced that since the resolutions had been printed and distributed to the members of the House prior to the meeting and the assignment of resolutions to the Resolutions Committee had also been presented to the House in writing, individual introduction of the resolutions would be waived, unless there would be objections voiced by the House. There were none, and the reading of the resolutions was waived.

Dr. Devany then announced that



Joseph S. McKell, MD, Chillicothe (left) and William T. Paul, MD, Columbus, representing 10th District.

Resolutions 21-91, 33-91, 68-91 and 69-91 were withdrawn. Resolutions from the Hospital Medical Staff Section were then assigned to the following committees: Resolution No. 73-91 and 74-91 to Reference Committee No. 1; Resolutions No. 75-91 and 76-91 to Reference Committee No. 2.

Committee on Emergency Resolutions Report

Dr. Devany, chair of the Emergency Resolutions Committee, announced that three emergency resolutions had met the criteria for acceptance in the bylaws for consideration by the House. Emergency Resolution 03-91 was referred to Reference Committee No. 3; Emergency Resolutions 04-91 and 05-91 were referred to Reference Committee No. 1.

House Recessed

Ronald Price, MD, Cleveland, moved to begin the Final Session of the House on Sunday at 10:00 a.m. rather than at 9:00 a.m. The motion was seconded, but defeated by the House.

Following announcement of reference committee meeting rooms and a reminder of the all-member reception following the House and the OMPAC dinner on Saturday, the House recessed until the final session at 9:00 a.m., Sunday, May 19, 1991. **OSMA**

Minutes of the Final Session, OSMA House of Delegates

The final session of the OSMA House of Delegates was convened at 9:05 a.m. on Sunday, May 19, 1991 by John A. Devany, MD.

INTRODUCTION OF HONORED GUESTS

Cyril M. Hetsko, Madison, Wisconsin, President-Elect of the State Medical Society of Wisconsin; Michael Stump, MD, President of the West Virginia Medical Society; and Robert N. Moyers, MD, President-Elect of the Pennsylvania Medical Society were introduced to the House at this time. Also recognized were Stephen P. Hogg, MD, Cincinnati, and H. William Porterfield, MD, Columbus, both past members of OSMA Council.

REPORT OF THE CHAIR OF THE CREDENTIALS COMMITTEE

Janet K. Bixel, MD, Franklin County, chair of the Credentials Committee, reported that out of 250 delegates eligible to vote, 216 were present, credentialed and seated.

ELECTION OF PRESIDENT-ELECT

Dr. Devany called for nominations for the office of President-Elect. Donavin A. Baumgartner, Jr., MD, Cleveland, placed in nomination Stanley J. Lucas, MD, Cincinnati. The nomination was seconded by Lee

Vesper, MD, Cincinnati.

William Dorner, MD, Akron, placed in nomination Jack L. Summers, MD, Akron. The nomination was seconded by William Kose, MD, Findlay. There were no nominations from the floor and a written ballot was ordered. Dr. Stanley J. Lucas was elected President-Elect. Dr. Summers congratulated Dr. Lucas and thanked those who supported his candidacy. John F. Kroner, Jr., MD, was re-elected to the position of Secretary-Treasurer.

REPORT OF THE NOMINATING COMMITTEE

Brian S. Gordon, MD, chair of the Nominating Committee, was called to the podium. The report of the Nominating Committee was presented to the House. The House approved the recommended candidates by acclamation.

For Councilors from the even-numbered districts for a two-year term, the following were elected: Second District — Walter A. Reiling, Jr., MD; Fourth District — Su-Pa Kang, MD; Sixth District — Robert C. Reed, MD; Eighth District — Thomas J. Hall, MD; Tenth District — Claire V. Wolfe, MD; Twelfth District — Jack L. Summers, MD, PhD.

For Delegates to the American Medical Association to serve terms commencing January 1, 1992 and ending December 31, 1993, the

following were elected: John E. Albers, MD, Cincinnati; Donavin A. Baumgartner, Jr., MD, Cleveland; John A. Devany, MD, Toledo; Edward G. Kilroy, MD, Cleveland; Henry G. Krueger, MD, Cleveland; William J. Marshall, MD, Dayton; Joseph Sudimack, Jr., MD, Columbus; Lee J. Vesper, MD, Cincinnati; and Claire V. Wolfe, MD, Columbus.

For Alternate Delegate to the American Medical Association, to serve terms commencing January 1, 1992 and ending December 31, 1993, the following were elected: Stephen T. House, MD, Dayton; Owen E. Johnson, MD, Columbus; William T. Paul, MD, Columbus; Ronald L. Price, MD, Cleveland; Victoria N. Ruff, MD, Columbus; Jack L. Summers, MD, Akron; and David J. Utlak, MD, Canton.

For Alternate Delegate to the American Medical Association, to serve a term commencing May 19, 1991 and ending December 31, 1991, Ronald L. Price, MD, Cleveland was elected.

For Alternate Delegate to the American Medical Association, to serve a term commencing January 1, 1992 and ending December 31, 1992, Frederick T. Suppes, MD, Cleveland, was elected.

Scott Kramarich, Cincinnati, was elected by the OSMA Medical Student Section as an Alternate Delegate for

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one year, commencing March 10, 1991, in accordance with Chapter 5, Section 7 of the OSMA Bylaws.

INAUGURAL CEREMONY

John O. Vlad, MD, Delegate from Trumbull County, escorted Dr. Sudimack's family to the podium. Dr. William Marshall administered the presidential oath of office to Dr. Sudimack, then presented Dr. Sudimack with the official gavel and the president's medallion.

Dr. Sudimack presented to Dr. Devany the Past President's pin, the President's plaque and a replica of the President's medallion.

Dr. Sudimack then briefly addressed the House. His remarks were followed by a standing ovation.

The meeting was turned over to Dr. Devany who thanked the OSMA Council, the House and the OSMA staff for their support during his year as president. Dr. Devany received a standing ovation from the House.

There being no further business, the House of Delegates adjourned. **OSMA**

REPORT OF REFERENCE COMMITTEE 1

David J. Utlak, MD, Stark County, Chair, presented the report of Resolution Committee No. 1. The House took action on the report as follows:

AMENDED RESOLUTION NO. 01-91

Third-Party Reimbursement for Telephone Time

RESOLVED, That the Ohio State Medical Association work with the appropriate parties to obtain approval of reimbursement to physicians for telephone calls required by third-party regulations relative to the complexity of these efforts as referred to in AMA policy compendium 33.007.

By official action, **the House voted to adopt Amended Resolution No. 01-91.**

RESOLUTION NO. 02-91

Reorganize OSMA as a Labor Union

RESOLVED, That the Ohio State Medical Association make application

to the appropriate authorities to become recognized as a labor union so that in matters of professional fees it may be able to legally represent its members who are presently prohibited by anti-trust laws from joining in such efforts.

By official action, **the House voted to reject Resolution No. 02-91.**

AMENDED SUBSTITUTE RESOLUTION NO. 03-91 (Replacing Nos. 03 & 04)

Increased Third-Party Payor Accountability

RESOLVED, That the Ohio State Medical Association promptly develop and introduce legislation in the Ohio General Assembly to:

- (a) require private review entities and payors to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed,
- (b) require that "non-covered" not be called "medically unnecessary,"
- (c) require that the attending physician be contacted for appropriate information before a denial of payment is sent to a patient; that no denial should be issued unless the case has been reviewed by a physician, not a nurse or a "claims analyst"; and that any reviewer physician who recommends a denial as to the medical necessity of services on behalf of a review entity be Board-certified in the same specialty as the practitioner who provided the services under review,
- (d) require that denials of covered services are specific rebuttals of the treating physician's diagnosis and treatment decisions,
- (e) require organizations that review the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group that is independent of the organization conducting the initial review,
- (f) require that any physician who

makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed and in the active practice of medicine in the same state as the practitioner who is proposing the service or whose services are being reviewed,

- (g) require that review entities respond within two business days to patient or physician requests for prior authorization, and that they have personnel, available by telephone the same business day, who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay,
- (h) require that any payor instituting prior authorization requirements, as a condition for plan coverage, provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician, and
- (i) require that payors compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claims forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay; and, be it further

RESOLVED, That such legislation should require disclosure in a standard form by health benefit plans to prospective enrollees of information on:

- (a) coverage provisions, benefits and exclusions,
- (b) prior authorized or other review requirements, including claims review, which may affect the provision or coverage of services,

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- (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient,
- (d) loss ratios; and, be it further

RESOLVED, That such legislation should hold third-party payors and their reviewing physicians liable for any patient harm resulting from third-party decisions regarding prior or concurrent approval of services resulting in unreasonable delay, reduction or denial of medically necessary services recommended by a physician; or for harm to enrollees resulting from failure to disclose, prior to enrollment, the information on plan provisions and operations as specified in the second resolve; and be it further

RESOLVED, That the OSMA, through its Ombudsman program, continue to obtain examples from members where potential harm to patients may have resulted from third-party payor intervention.

By official action, **the House voted to amend Substitute Resolution No. 03-91, as indicated with deletions, and to adopt it as amended.**

AMENDED RESOLUTION NO. 05-91

Reimbursement Rates for Medical Services to Medicaid Patients

RESOLVED, That the Ohio State Medical Association encourage the Ohio Legislature to increase funding to the Ohio Department of Human Services and to develop incentives for better patient access by ~~lowering medical-malpractice-risk-and~~ creating equitable reimbursement rates in line with other third-party payors **AND IN COMPLIANCE WITH OBRA-1990.**

By official action, **the House voted to amend Amended Resolution No. 05-91, as indicated in capital letters with deletions as noted, and to adopt it as amended.**

RESOLUTION NO. 06-91

Correct Rural Medicare Payment Inequality

RESOLVED, The Ohio State Medical Association should investigate

reasons for such lower payments to rural areas and if necessary request legislative assistance to correct lower Medicare payments to rural areas of Ohio.

By official action, **the House referred Resolution No. 06-91 to the OSMA Council.**

RESOLUTION NO. 07-91

Medicare Discrimination Against Huron County

RESOLVED, That the Ohio State Medical Association House of Delegates request the Director of Medicare Region No. 5, in Chicago, to conduct an investigation and submit a report at the earliest possible time, no later than May 1992; and, be it further

RESOLVED, That a copy of this resolution be sent to all the news, radio and television media in Huron County suggesting that they might do an independent investigation to ferret out any reason for what would seem to be an apparent discrimination affecting patients and physicians alike.

By official action, **the House referred Resolution No. 07-91 to the OSMA Council.**

AMENDED RESOLUTION NO. 08-91

Mandatory Reimbursement for FDA-Approved Antineoplastic Chemotherapy Drugs Used in Non-FDA-Listed Indications

RESOLVED, That the Ohio State Medical Association supports state legislation requiring insurers to provide coverage for non-FDA-approved use of antineoplastic chemotherapy drugs, whose efficacy is recognized as outlined below; and, be it further

RESOLVED, That language similar to that introduced in the 1989 Michigan Senate be adopted, which is stated as follows:

A health-care corporation shall provide coverage in each group and non-group certificate for a federal Food and Drug Administration approved drug used in antineoplastic chemotherapy and the reasonable cost of its administration. Coverage shall be provided regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug

has received approval by the federal FDA if all of the following conditions are met:

- a) the drug is ordered by a physician for treatment of a specific type of neoplasm.
- b) the drug is approved by the federal FDA for use in antineoplastic chemotherapy.
- c) the drug is used as part of a antineoplastic drug regimen.
- d) current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.
- e) the physician has obtained informed consent from the patient for the treatment program.

and, be it further

RESOLVED, That the legislation recognize the expertise of the panel of practicing oncologists from Ohio formed by the Ohio/West Virginia Oncology Society in recommending the current indications for the use of such antineoplastic chemotherapy drugs.

By official action, **the House voted to adopt Amended Resolution 08-91.**

RESOLUTION NO. 09-91

Health Benefit Plans

RESOLVED, That the Ohio State Medical Association investigate a means of requiring that those employers who provide health insurance to their employees and are required by Ohio law to offer at least one HMO program, also offer the option of a traditional fee-for-service health benefit plan as a part of their benefit package.

By consent, **the House adopted Resolution No. 09-91.**

AMENDED RESOLUTION NO. 10-91

Standardized

Explanation of Benefits to Patients

RESOLVED, That the Ohio State Medical Association (OSMA) work with third-party payors to develop a standardized explanation of benefits to patients that may include the following information: 1) day of service; 2) place of service; 3) billing parties; 4) CPT code and description of service; and, be it further

RESOLVED, That the OSMA attempt to educate physicians to

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include the same information in their billing statements.

By official action, the House voted to adopt Amended Resolution No. 10-91.

SUBSTITUTE RESOLUTION NO. 11-91

(Replacing Nos. 11 & 12) Opposition to HCFA's Cataract Surgery Alternate Payment Demonstration Project

RESOLVED, That the Ohio State Medical Association strongly supports and joins the opposition of the American Academy of Ophthalmology to the Health Care Financing Administration's implementation of cost-driven limitations of patient services as exemplified by the Cataract Surgery Alternate Payment Demonstration Project; and, be it further

RESOLVED, That the OSMA attempt to inform the public of the potential implications of this proposal on the physician/patient relationship and access to quality care; and, be it further

RESOLVED, That the OSMA inform Ohio's members of the U.S. House of Representatives and Senate of its opposition to HCFA's Procedural PPOs.

By official action, the House voted to adopt Substitute Resolution No. 11-91.

AMENDED RESOLUTION NO. 13-91

Physician and Medical Staff Liability in Managed Care and Hospital PPO Contracts

RESOLVED, That all members of the OSMA be advised that hospital efforts to broker their professional services as members of the medical staff by a hospital health care plan be carefully reviewed, and that the physician should consider utilizing available review resources including OSMA contract analysis services, and consultation with the physician's attorney, accountant or adviser; **AND, BE IT FURTHER**

RESOLVED, THAT THE OSMA MEMBER BE AWARE THAT ANY MANAGER PLANS:

- A) HAVE THE POSSIBILITY OF CIVIL AND CRIMINAL ANTITRUST LIABILITY,
- B) MANDATORY REFERRAL TO CERTAIN SPECIALISTS AND HOSPITALS EXCLUSIVELY,
- C) UTILIZATION REVIEW PROCEDURES WHICH ARE NOT DEFINED,
- D) THE LOSS OF THE PHYSICIAN'S RIGHT TO JOIN SIMILAR OR COMPETING PLANS,
- E) THE REQUIREMENT OF HAVING TO PROVIDE 24-HOUR COVERAGE TO PATIENTS,
- F) THE BROKERING OF SERVICES SO THAT A PHYSICIAN DOES NOT KNOW UPON WHAT BASIS HE WILL BE COMPENSATED,
- G) THE POTENTIAL FOR HAVING TO CARE FOR AN UNLIMITED NUMBER OF PATIENTS,
- H) THE LOSS OF STATUTORY IMMUNITY FROM LIABILITY FOR PEER REVIEW, AND
- I) THE RIGHT OF THE PLAN TO WITHHOLD AN UNSTATED AMOUNT THAT MAY NEVER BE PAID TO THE PHYSICIAN.

By official action, the House amended Amended Resolution No. 13-91, as indicated in capital letters with deletions as noted, and referred it to the OSMA Council.

AMENDED RESOLUTION NO. 14-91

Timely Early Disclosure of All Limiting Charges Information

RESOLVED, That the Ohio State Medical Association (OSMA) work with HCFA to allow a 30-day decision period between the time that the full and complete schedule of limiting charges is made available by the carrier and the deadline date for the decision on whether to become a "Participating Physician"; and, be it further

RESOLVED, That the OSMA forward a similar resolution to the AMA House of Delegates for consideration at the 1991 AMA Annual Meeting.

By official action, the House voted to adopt Amended Resolution No. 14-91.

RESOLUTION NO. 15-91 Cost of Medical Care — Market Research Study

RESOLVED, That the OSMA and AMA finance a detailed study of the cost of medical care by a reputable market research firm; and, be it further

RESOLVED, That the cost of medical care be compared to the cost of other service-oriented industries; and, be it further

RESOLVED, That the results of the study be publicized regardless of whether the findings justify the cost of medical care or not; and, be it further

RESOLVED, That if the study shows that we, the physicians, charge too much and it is not justified, that we must be willing to roll back our charges.

By official action, the House voted to reject Resolution No. 15-91.

RESOLUTION NO. 16-91 Medical Economics

RESOLVED, That the Council of OSMA ~~charter an "Ohio Health-Care-Commission"~~ **ESTABLISH A COMMITTEE** to consider the problems of health care economics and propose both immediate and long-range programs for the solution of these problems to the OSMA House of Delegates at its 1992 session.

By official action, the House voted to amend Resolution No. 16-91, as indicated in capital letters with deletions as noted, and referred it to the OSMA Council.

RESOLUTION NO. 17-91 Co-Sponsorship of CME Programs

RESOLVED, That it be the policy of the OSMA to cooperate with component societies in offering accredited continuing medical education programs; and, **be it further**

RESOLVED, That requirements, that inhibit component societies from seeking co-sponsorship with OSMA be removed, except those requirements of the ACCME.

By official action, the House voted to reject Resolution No. 17-91.

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RESOLUTION NO. 18-91

Prevention of the Overmedication of Elderly Patients

RESOLVED, That the Ohio State Medical Association (OSMA) support an educational campaign, coordinating the efforts of local medical societies and senior citizen groups on the hazards of taking multiple prescriptions and over-the-counter medications; and, be it further

RESOLVED, That the OSMA conduct a study to investigate the feasibility of establishing Patient Medical Profiles for Ohio citizens age 65 years and older; and, be it further

RESOLVED, That this study also evaluate the use of a credit card-sized, portable, electronically readable and modifiable data care storage and retrieval system, for the storage of such medical records.

By official action, the House referred Resolution No. 18-91 to the OSMA Council.

AMENDED RESOLUTION NO. 19-91

Quality of Life Issues Considered in Life Prolonging Therapy

RESOLVED, That the Ohio State Medical Association reaffirm the physician's primary role in guiding the patient, family and other members of the health care team to consider both the quality of life as well as the longevity of life when making medical treatment decisions. ~~AND BE IT FURTHER~~

~~RESOLVED, THAT THE OSMA ENCOURAGE THOSE INVOLVED IN REGULATORY ACTIVITIES AND ALSO CONSIDER BOTH THE QUALITY OF LIFE AS WELL AS THE LONGEVITY OF LIFE WHEN MAKING MEDICAL TREATMENT DECISIONS.~~

By official action, the House amended Amended Resolution No. 19-91, as indicated with deletions, and adopted it as amended.

RESOLUTION NO. 20-91

Private Sector Proposal for Part B Medicare

RESOLVED, That the Ohio State Medical Association (OSMA) House

of Delegates recommend to OSMA Council to appoint an ad hoc committee to investigate the possibility of private insurance companies coming together to develop an alternative plan for Part B Medicare — thus challenging the private sector to take over the Part B Medicare.

By consent, the House rejected Resolution No. 20-91.

RESOLUTION NO. 21-91 — WITHDRAWN

Membership Campaign

RESOLUTION NO. 73-91

Physician Fee Determination by Contractual Arrangement Between Third-Party Payors and Hospitals

RESOLVED, That the Ohio State Medical Association condemn the practice of negotiating for and/or the creation of contractual arrangements between third-party payors and hospitals that set or limits fee-for-service provided by physicians in private practice unless those physicians have given explicit consent; and, be it further

RESOLVED, That the OSMA in cooperation with the AMA study the magnitude and potential impact of such agreements including the antitrust implications; and, be it further

RESOLVED, That the OSMA in cooperation with the AMA solicit the cooperation and support of the American Hospital Association and its members in this endeavor.

By consent, the House adopted Resolution No. 73-91.

AMENDED RESOLUTION NO. 74-91

Recognition of OSMA-HMSS Founders

RESOLVED, That the Ohio State Medical Association Hospital Medical Staff Section Assembly express gratitude and thanks to the following Ohio physicians for their many contributions to the establishment of the OSMA-HMSS:

Lawrence A. Dils, MD
William Dorner, Jr., MD
John F. Dotter, MD
Eugene A. Feldheimer, MD
Edward E. Grable, MD

Owen E. Johnson, MD
Keith P. Kaufman, MD
Edward G. Kilroy, MD
A. Gus Kious, MD
Raymond J. McMahon, Jr., MD
Richard J. Nowak, MD
Gary L. Ray, MD
Frederick T. Suppes, MD
Charles B. Travis, MD

and, be it further

RESOLVED, That the Ohio State Medical Association Hospital Medical Staff Section and the OSMA express extreme gratitude and thanks to Edmund W. Jones, MD, for his tireless, dedicated and exceptionally effective chairmanship of the OSMA-HMSS from 1985 to 1991.

By official action, the House voted to adopt Amended Resolution No. 74-91.

EMERGENCY RESOLUTION NO. 04-91

Coverage of Drugs by Medicaid

RESOLVED, That the Ohio State Medical Association (OSMA) beseech the Health Care Financing Administration to develop meaningful guidelines for state Medicaid agencies to pay for drugs necessary to treat life-threatening and other serious medical conditions, even if such drugs are manufactured/distributed by non-rebating firms; and, be it further

RESOLVED, That the OSMA ask the Health Care Financing Administration to grant states reasonable autonomy in decisions to cover these medically necessary drugs without retroactive economic penalty; and, be it further

RESOLVED, That the OSMA present this matter to the American Medical Association for action, and send a copy of this resolution to all Ohio senators and representatives in the U.S. Congress.

By official action, the House voted to adopt Emergency Resolution No. 04-91.

AMENDED EMERGENCY RESOLUTION NO. 05-91

OBRA '90 Medicaid Reimbursement for Prescription Drugs

RESOLVED, That the Ohio State

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Medical Association (OSMA) strongly encourages the Health Care Financing Administration to proceed with the mandate of OBRA '90 for Medicaid reimbursement for prescription drugs with due caution; and, be it further

RESOLVED, That the criteria for establishment of price "upper limits" for multisource drugs should encompass the following considerations

1. Bioequivalency of *all* the multisource drugs (i.e., "A" rated generics).
2. Due consideration for drugs that have narrow therapeutic windows of effectiveness.
3. Due consideration for drugs with a history of significant adverse drug reaction reports.
4. Even if an "upper limit" must be established if there are at least three "A" rated equivalents, all of the "A" rated equivalents available must be manufactured by firms that have no unresolved improprieties in their dealings with the Food and Drug Administration.
5. Availability must be certified by more than the mere observation that a listing of the drug appears in some catalogue or database.
6. Due consideration for the bottom-line economic impact of the decision, as it is unrealistic to expect that the mere establishment of a price "upper limit" will guarantee tax dollar savings for a particular drug category.
7. A comment period should be allowed for state Medicaid administrators and state Medicaid pharmacy and therapeutics committees prior to implementation of new price "upper limits" on drugs; and, be it further

RESOLVED, That the OSMA present this matter to the American Medical Association for action, and send a copy of this resolution to all Ohio senators and representatives in the U.S. Congress; and, be it further

RESOLVED, That the OSMA develop an educational program related to generic drugs and their bioavailability and that this information be disseminated to physicians.

By official action, the House voted

to adopt Amended Emergency Resolution No. 05-91.

REPORT OF REFERENCE COMMITTEE NO. 2

Donna A. Woodson, MD, Chair, Lucas County, presented the report of Resolutions Committee No. 2. The House took action on the report as follows:

AMENDED RESOLUTION NO. 22-91

Health Access America Credibility

RESOLVED, That the Ohio State Medical Association ask the American Medical Association to continue to refine and improve Health Access America to incorporate additional approaches which are consistent with improved access and continued quality, and which reflect physicians' accountability and responsibility in appropriate cost containment.

By official action, the House voted to adopt Amended Resolution No. 22-91.

RESOLUTION NO. 23-91

Peer Review Organization Quality Assurance — Burden of Proof

By consent, the House rejected Resolution No. 23-91.

RESOLUTION NO. 24-91

Ohio State Medical Association Peer Review Process

By official action, the House voted to reject Resolution No. 24-91.

RESOLUTION NO. 25-91

House Bill 65

By official action, the House voted to reject Resolution No. 25-91.

RESOLUTION NO. 26-91

Concurrent Care

By official action, the House voted to reject Resolution No. 26-91.

RESOLUTION NO. 27-91

PRO Quality Inquiry Letter

RESOLVED, That the Ohio State Medical Association (OSMA) request the American Medical Association (AMA) to reconsider its actions related to the first PRO "Quality Inquiry Letter" and to lobby HCFA to mandate to PRO provide a copy to the

hospital of the "Quality Inquiry Letter"; and, be it further

RESOLVED, That the OSMA request the AMA to lobby HCFA to require the PRO to implement a mechanism to verify receipt by the hospital of the PRO's "Quality Inquiry Letter"; and, be it further

RESOLVED, That OSMA forward this resolution to the AMA for consideration at the 1991 Annual Meeting.

By official action, the House referred Resolution No. 27-91 to the OSMA Council, with a report back at the 1992 House of Delegates.

RESOLUTION NO. 28-91

PRO Hospital Comparison Data

By official action, the House voted to reject Resolution No. 28-91.

AMENDED RESOLUTION NO. 29-91

PRO — Abuse of Statutory and Regulatory Power

RESOLVED, That the PRO not intentionally interfere or inappropriately influence appointments to quality assurance and/or utilization review committees made by hospital medical staff or administration; and, be it further

RESOLVED, That OSMA reaffirm the importance of medical staff independence and self-governance pursuant to the terms of the hospital staff bylaws; and, be it further

RESOLVED, That the OSMA forward this resolution to the AMA for the 1991 Annual Meeting.

By official action, the House voted to adopt Amended Resolution No. 29-91.

RESOLUTION NO. 30-91

Revising the PRO

By official action, the House voted to reject Resolution No. 30-91.

AMENDED RESOLUTION NO. 31-91

Unannounced PRO Enforcement of Regulation

RESOLVED, That the Ohio State Medical Association (OSMA) and the American Medical Association (AMA) petition HCFA to preclude application of a law, rule or regulation prior to its effective date; and, be it further

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RESOLVED, That HCFA announce the date on which the enforcement of a law, rule or regulation applicable to the Medicare program will begin.

By official action, **the House voted to adopt Amended Resolution No. 31-91.**

AMENDED RESOLUTION NO. 32-91 PRO Physician Adviser Confidentiality

RESOLVED, That the Ohio State Medical Association (OSMA) and the American Medical Association (AMA) petition HCFA to annually require the state PRO to publish and forward to the quality assurance chair and the chief of staff or medical director of all hospitals under its jurisdiction the names of physician advisers and their specialties; **AND, BE IT FURTHER**

RESOLVED, THAT THE OSMA ASK THE AMA TO URGE HCGA TO REQUIRE THE PHYSICIAN ADVISER(S) SIGN THEIR NAMES AND SPECIALTY ON "LETTERS OF INQUIRY"; AND, BE IT FURTHER

RESOLVED, That OSMA forward this resolution to the AMA for consideration at the 1991 Annual Meeting.

By official action, **the House voted to amend Amended Resolution No. 32-91, as indicated in capital letters with deletions as noted, and to adopt it as amended.**

RESOLUTION NO. 33-91 — WITHDRAWN Emeritus OSMA Delegates to the AMA

AMENDED RESOLUTION NO. 34-91 Child Care in Hospitals

RESOLVED, That the Ohio State Medical Association strongly encourage hospitals to establish child care provisions for hospital personnel and staff physicians; and, be it further

RESOLVED, That the hours and staffing of child care facilities should take the needs of physicians-in-training and medical students into consideration.

By official action, **the House voted to adopt Amended Resolution No. 34-91.**

RESOLUTION NO. 35-91 Support for Health Clinics

RESOLVED, That the Ohio State Medical Association develop and seek the enactment of legislation to provide liability immunity for physicians who volunteer to work without compensation in free clinics or in clinics that are operated by city or county health departments in Ohio.

By consent, **the House adopted Resolution No. 35-91.**

AMENDED RESOLUTION NO. 36-91 Pre-Admission Evaluations by Limited Practitioners

RESOLVED, That the OSMA urge the American Medical Association to take appropriate action to challenge programs in which the need for hospitalization is determined by non-physicians; **AND, BE IT FURTHER**

RESOLVED, THAT THIS RESOLUTION BE FORWARDED TO THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES FOR ITS CONSIDERATION AT THE 1991 INTERIM MEETING.

By official action, **the House voted to amend Amended Resolution No. 36-91, as indicated in capital letters with deletions as noted, and to adopt it as amended.**

RESOLUTION NO. 37-91 Limiting Terms of Office in the AMA

RESOLVED, That the Ohio State Medical Association forward a resolution to be considered at the 1991 AMA annual meeting asking the AMA Board of Trustees, to review all AMA Councils and the Board, with respect to the following: 1) the terms of office; 2) the maximum number of terms; and 3) whether the Councils are elected or appointed, for the purpose of facilitating more rapid involvement in leadership positions of young physicians, women, international medical graduates and other minorities.

By consent, **the House adopted Resolution No. 37-91.**

RESOLUTION NO. 38-91 Substance Abuse Questions on Hospital Staff

Application/Reapplication Forms

RESOLVED, That the Ohio State Medical Association (OSMA), with the assistance of the Ohio Hospital Association, encourage all hospitals to adopt the same wording used by the Ohio State Medical Board on its application for relicensure; and, be it further

RESOLVED, That OSMA work with the Ohio Department of Insurance and other appropriate insurance organizations to urge managed health care plans to use the Ohio State Medical Board's wording on their physician application/reapplication forms.

By official action, **the House referred Resolution No. 38-91 to the OSMA Council.**

AMENDED RESOLUTION NO. 39-91 Expert Witness Testimony

RESOLVED, That the Ohio State Medical Association (OSMA) affirms the belief that qualified expert witnesses in medical malpractice actions should devote three-fourths of their professional time to active clinical practice in their field of specialty.

By official action, **the House voted to adopt Amended Resolution No. 39-91.**

AMENDED RESOLUTION NO. 40-91 Hospital Medical Staff Physicians "Bill of Rights"

RESOLVED, That a joint committee consisting of members of the Ohio State Medical Association (OSMA) and the Ohio Hospital Association (OHA) be formed to develop recommendations regarding the respective authority, rights and obligations of the board of trustees, hospital administration and medical staff within the hospital environment; and, be it further

RESOLVED, That this committee create a physician's "bill of rights" within the hospital organization. These rights shall include, but are not limited to, the free election of medical staff officers, either election of or concurrence with the appointment of clinical division directors, professional credentialing of the medical staff membership and freedom from

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economic pressures by the hospital administration which may conflict with a physician's responsibilities in caring for patients.

By official action, the House voted to adopt Amended Resolution No. 40-91.

AMENDED RESOLUTION NO. 41-91 **Inclusion of National Board of Medical Examiners Registration Fees Within Tuition Payments**

RESOLVED, That the American Medical Association in conjunction with the Liaison Committee for Medical Education encourage all medical schools to have the NBME registration fees incorporated into the second-and fourth-year student financial aid budgets; and, be it further

RESOLVED, That the OSMA urge the AMA, working in conjunction with the Liaison Committee for Medical Education, to encourage schools that have procedures in place for paying the NBME registration fees to offer the option to students to have these fees included in the tuition statements.

By official action, the House voted to adopt Amended Resolution No. 41-91.

RESOLUTION NO. 42-91 **Certificate of Medical Necessity** By consent, the House rejected Resolution No. 42-91.

RESOLUTION NO. 43-91 **Advertising Board Certification** RESOLVED, That the Ohio State Medical Association endorse legislation prohibiting physicians from advertising Board certification or eligibility unless the Board:

Is approved by the American Board of Medical Specialties; or is approved by the Ohio State Medical Board as having requirements equal to those of the American Board of Medical Specialties; or requires completion of a post-graduate training program in the advertised specialty that is approved by the Accreditation Council of Graduate Medical

Education.

By official action, the House referred Resolution No. 43-91 to the OSMA Council, with a report back at the 1992 House of Delegates.

RESOLUTION NO. 44-91 **Women in Medicine**

RESOLVED, That the House of Delegates recognize and support women members of this association in their efforts to participate at the operational levels in the formulation of policy for all Ohio State Medical Association programs and projects.

By consent, the House adopted Resolution No. 44-91.

RESOLUTION NO. 75-91 **Economic Credentialing**

RESOLVED, That the Ohio State Medical Association oppose the use of economic criteria not related to quality to determine an individual physician's qualifications for the granting or renewal of medical staff membership or privileges.

By consent, the House adopted Resolution No. 75-91.

RESOLUTION NO. 76-91 **OSMA Legal Counseling Services for Hospital Medical Staff Bylaws Concerns**

RESOLVED, That the OSMA establish a Hospital Medical Staff Legal Counseling Service.

By official action, the House referred Resolution No. 76-91 to the OSMA Council, with a report back at the 1992 House of Delegates.

REPORT OF REFERENCE COMMITTEE NO. 3

Mary Jo Welker, MD, Chair, Franklin County, presented the report of Resolutions Committee No. 3. The House took action on the report as follows:

AMENDED SUBSTITUTE RESOLUTION NO. 45-91 **(Replaces 45, 47 & 48)** **HIV Testing**

RESOLVED, That the Ohio State Medical Association (OSMA) propose state legislation to amend Ohio Revised Code section 3701.242, to

permit physicians to test patients for HIV infection as currently permitted under Ohio Revised Code for other communicable diseases; and, be it further

RESOLVED, That the OSMA propose legislation to require HIV anonymous test sites to develop a code for identifying and notifying infected individuals who do not return for their test results, AND, BE IT FURTHER

RESOLVED, THAT THE OSMA RECOMMENDS MORE ROUTINE HIV TESTING OF PATIENTS, ESPECIALLY PREGNANT WOMEN, INNER CITY CLINIC PATIENTS, STD PATIENTS AND PATIENTS GOING TO SURGERY.

By official action, the House voted to amend Substitute Resolution No. 45-91, as indicated in capital letters with deletions as noted, and to adopt it as amended.

AMENDED RESOLUTION NO. 46-91 **HIV Testing**

RESOLVED, That the Ohio State Medical Association pursue state legislation that would require the medical community to treat HIV infection like other communicable diseases to include TESTING, reporting, tracking, and contact tracing.

By official action, the House voted to amend Amended Resolution No. 46-91 as indicated in capital letters with deletions as noted, and to adopt it as amended.

RESOLUTION NO. 49-91 **AIDS Resolution Regarding Individual Hospital HIV Policies**

RESOLVED, That the Ohio State Medical Association (OSMA) recommend legislation to provide that physicians who comply with a hospital's HIV infectious disease policy be held harmless from litigation for breach of privacy when reporting HIV positive individuals to the appropriate infectious disease committee of the hospital; and, be it further

RESOLVED, That the OSMA recommend that the American Medical Association adopt as policy that physicians who comply with a hospital's HIV infectious disease policy

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be held harmless from litigation for breach of privacy when reporting HIV positive individuals to the appropriate infectious disease committee of the hospital.

By official action, the House referred Resolution No. 49-91 to the OSMA Council.

RESOLUTION NO. 50-91 Safety Net for Health Professionals Who Become HIV Seropositive on the Job

RESOLVED, That the Ohio State Medical Association (OSMA) work with the Ohio Hospital Association to develop model policy for hospitals and other employers of health care workers to indemnify their employees who acquire HIV seropositive in the course of their duties so that they are protected from economic loss due to their inability to practice; and, be it further

RESOLVED, That the OSMA work with the insurance industry to develop insurance plans that can be purchased by employers of health professionals and self-employed health professionals to protect persons who become HIV seropositive in the course of their duties from the resulting inability to practice their profession.

By official action, the House referred Resolution No. 50-91 to the OSMA Council.

RESOLUTION NO. 51-91 Support For and Development of Statewide Risk Pools for HIV Positive Physicians

By consent, the House rejected Resolution No. 51-91.

RESOLUTION NO. 52-91 Expansion of Workers' Compensation Benefits for HIV-Positive Physicians

RESOLVED, That the Ohio State Medical Association (OSMA) actively pursue legislation that calls for the expansion and benefits under workers' compensation to include AIDS-related complications under bloodborne diseases and support such legislation already in existence; and, be it further

RESOLVED, That the OSMA forward this resolution to the I-91 AMA meeting as an Ohio resolution.

By official action, the House referred Resolution No. 52-91, to the OSMA Council.

RESOLUTION NO. 53-91 Prevention of Sexually Transmitted Human Papillomavirus (HPV) Infections

RESOLVED, That the Ohio State Medical Association promote human papillomavirus infection awareness and prevention by the development of educational material to be distributed to media and the general public.

By consent, the House adopted Resolution No. 53-91.

RESOLUTION NO. 54-91 Ohio State Medical Board Categorization of Physician Penalties

RESOLVED, That the Ohio State Medical Association seek the Ohio State Medical Board's cooperation in listing affected physicians by the varying degrees of severity of actions pending against them.

By consent, the House adopted Resolution No. 54-91.

RESOLUTION NO. 55-91 Ohio State Medical Board Investigations

RESOLVED, That the Ohio State Medical Association (OSMA) work with the Ohio State Medical Board on decreasing the length of time involved in case investigations; and, be it further

RESOLVED, That OSMA recommend the Ohio State Medical Board provide regular investigation updates to county medical societies.

By official action, the House voted to adopt Resolution No. 55-91.

AMENDED RESOLUTION NO. 56-91 Ohio State Medical Board Proposed Licensure Legislation

RESOLVED, That the House of Delegates direct the Ohio State Medical Association (OSMA) to support retention of the requirement that international medical school graduates applying for reciprocity in the state of Ohio need only 24 months of graduate medical education if licensed by a reciprocating state and have completed five years of

competent practice in that state; and be it further

RESOLVED, That the House of Delegates direct the OSMA to support the requirement that international medical school graduates may take FLEX exam after completion of one year of post graduate education.

By official action, the House voted to amend Amended Resolution No. 56-91, as indicated in capital letters with deletions as noted, and to refer it as amended to the OSMA Council.

RESOLUTION NO. 57-91 Cancer Registry

RESOLVED, That the Ohio State Medical Association (OSMA) House of Delegates ask the appropriate officers and directors of the association to meeting with key legislators to urge the introduction and passage of legislation regarding a statewide cancer registry which is to be administered by the Ohio Department of Health; and, be it further

RESOLVED, That information in this regard be forwarded to the presidents of all the component medical societies of OSMA in order that they may urge their membership to contact local legislators to urge support of this program.

By consent, the House adopted Resolution No. 57-91.

AMENDED RESOLUTION NO. 58-91 Medical Licensure

RESOLVED, That the Ohio State Medical Association House of Delegates direct the appropriate officers of the association to meet with the Ohio State Medical Board to guarantee receipt of the physicians' new licenses by the renewal date of the appropriate year.

By official action, the House voted to adopt Amended Resolution No. 58-91.

AMENDED RESOLUTION NO. 59-91 WTI — Waste Incinerator

RESOLVED, That the Ohio State Medical Association (OSMA) express its opposition to the appropriate authorities regarding the construction and eventual operation of the hazardous waste incineration plant by

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WTI in East Liverpool, Ohio; and be it further

RESOLVED, That the OSMA express its grave concern to appropriate authorities regarding the development of similar plants and importation of hazardous waste into Ohio; and, be it further

RESOLVED, That the OSMA establish or assign one of its committees to study the problems of hazardous waste so that concerned members may have access to the most recent state and federal guidelines and be able to advise community leaders on how to address the growing public concern about hazardous waste.

By official action, the House voted to adopt Amended Resolution No. 59-91.

AMENDED RESOLUTION NO. 60-91 Education of Students on the Hazards of Ultraviolet Radiation (Tanning Rays)

RESOLVED, That the Ohio State Medical Association work with the Ohio State Board of Education to include in the curriculum appropriate information for teachers to educate their students about the hazards of ultraviolet radiation; and, be it further

RESOLVED, That a similar resolution be forwarded to the American Medical Association for consideration.

By official action, the House voted to adopt Amended Resolution No. 60-91.

AMENDED RESOLUTION NO. 61-91 Infectious Disease Precautions for Cadaver Transport

RESOLVED, That Ohio State Medical Association seek legislation that requires that hospitals and morgues put an infectious disease warning tag on all bodies determined to have died of a reportable infectious disease, such as TB, syphilis, serum hepatitis, or HIV.

By official action, the House voted to adopt Amended Resolution No. 61-91.

SUBSTITUTE RESOLUTION NO. 62-91 (Replacing Nos. 62 & 63)



Victoria Ruff, MD, left and Claire Wolfe, MD at final session of the House of Delegates

Mandatory Use of Protective Helmets

RESOLVED, That the Ohio State Medical Association, recognizing the loss of useful life and expense of care resulting from head trauma occurring in motorcycle or other unprotected vehicle crashes, support legislation that will require the use of protective helmets at all times when operating motorcycles, bicycles, ATVs, mopeds and snowmobiles.

By official action, the House voted to adopt Substitute Resolution No. 62-91.

RESOLUTION NO. 64-91

Permanent Cosmetic Make-Up

RESOLVED, That the Ohio State Medical Association urge the Ohio State Medical Board to stipulate that injection of permanent cosmetic make-up constitutes the practice of medicine.

By official action, the House voted to adopt Resolution No. 64-91.

RESOLUTION NO. 65-91

Substance Abuse As A Public Health Hazard

RESOLVED, That the Ohio State Medical Association strongly oppose

legalization of any presently illegal drugs of substance abuse, including but not limited to, marijuana and cocaine.

By official action, the House voted to adopt Resolution No. 65-91.

RESOLUTION NO. 66-91

In Recognition of Thomas E. Fox, MD

RESOLVED, That the Ohio State Medical Association recognize Thomas E. Fox, MD for his 35 years of distinguished service to organized medicine at the county, state and national level.

By consent, the House adopted Resolution No. 66-91.

AMENDED RESOLUTION NO. 67-91

Sample Medication Packaging

RESOLVED, That the Ohio State Medical Association requests that all pharmaceutical companies distributing medicine samples to physicians' offices in the state of Ohio voluntarily comply with the request that all sample medicines being distributed in Ohio be packaged in such a way that a blank place be included in the packaging material so that the physician can

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write specific instructions on the sample container as to how the medicine should be taken.; and, be it further

RESOLVED, That a similar resolution be forwarded to the American Medical Association for consideration.

By official action, the House voted to adopt Amended Resolution No. 67-91.

RESOLUTION NO. 68-91 — WITHDRAWN Medical Student Page of OHIO Medicine

RESOLUTION NO. 66-91 — WITHDRAWN "The Delegate's Report"

**RESOLUTION NO. 70-91
Osteopathy 100-Year Anniversary**
RESOLVED, That the Ohio State Medical Association (OSMA) ask the American Medical Association (AMA) at the 1991 Annual Meeting to adopt an appropriate congratulatory message for the American Osteopathic Association on the occasion of their celebration of providing quality health care in America; and, be it further

RESOLVED, That the OSMA ask the AMA at the 1991 Annual Meeting to work jointly with the American Osteopathic Association and support America Osteopathic Association members in their petition to the Postmaster General of the United States to issue an American Osteopathic Association centennial commemorative stamp in the recognition of the 100-year anniversary that the American Osteopathic Association has provided quality health care in America.

By consent, the House adopted Resolution No. 70-91.

**AMENDED EMERGENCY
RESOLUTION NO. 03-91
State Medical Board Investigations**
RESOLVED, That the Ohio State Medical Association, through its Council petition the Attorney General of the state of Ohio and the Governor of the state of Ohio to ensure that the rights of the individual physician be

protected through "due process" mechanisms and the basic Constitutional rights, to face the accusers in any proceedings affecting the physician's right to practice medicine in the state of Ohio.

By official action, the House voted to adopt Amended Emergency Resolution No. 03-91.

REPORT A — 1991 Committee to Review OSMA House of Delegates Policy POLICIES TO BE RETAINED — 1987 HOUSE OF DELEGATES PROCEEDINGS

- 7-87 Physician Inclusion in Medicare DRG Program
- 10-87 Second Opinion Plans
- 11-87 Patient Care Concerns
- 12-87 Standardized Insurance Forms
- 14-87 Opposition to Government Legislated Physician Fee Controls and Services Under Medicare
- 15-87 Assignment of Health Insurance Benefits
- 23-87 OMPAC
- 33-87 HB 150 Constitutional Malpractice
- 35-87 OSMA Policy on Advertising
- 42-87 Community Liaison Regarding AIDS
- 43-87 Alcohol Treatment
- 48-87 Labeling of Generic Substitutions
- 52-87 Reaffirmation of Resolution 46-84: Mandatory Use of Protective Helmets for Motorcyclists
- 55-87 Early Detection
- 57-87 Student-to-Student Community Health Education Project
- 58-87 Smoke-Free Environment

POLICIES NOT TO BE RETAINED — 1987 HOUSE OF DELEGATES PROCEEDINGS

- 00-87 Establishment of a Resident Physicians' Section Within the OSMA
- 1-87 Medical Specialty Society Representation
- 6-87 Study of Alternative Structures
- 26-87 Medical Staff Bylaws
- 40-87 AIDS Campaign

- 44-87 Reaffirmation of Resolution No. 58-84: Public Purchase and Consumption of Alcoholic Beverages
- 46-87 Office Dispensing of Prescription Drugs
- 49-87 Parking for Temporarily Handicapped
- 51-87 Statewide Ethics Committee Report A Policies to be Retained — 1983 House of Delegates Proceedings

POLICIES NOT TO BE RETAINED — 1929 THROUGH 1986

- 14-76 Smoking Ban in Hospitals
- 66-80 Establishment of a Liaison Committee for Communication and Interaction with the EPA and With State County Health Commissioners
- 30-83 Therapeutic Substitution
- 27-85 Medical Professional Liability

By consent, the House adopted Report A — 1991.

Summary of Actions . . . continued

bioavailability and that this information be disseminated to physicians.

Inclusion of National Board of Medical Examiners Registration Fees Within Tuition Payments (OSMA Am. Res. 41-91)

The AMA House of Delegates **amended** the resolution submitted by the Ohio Delegation and **adopted** it as follows:

RESOLVED, That the American Medical Association ~~in conjunction with the liaison Committee for Medical Education~~, encourage all medical schools to have the National Board of Medical Examiners (NBME) registration fees incorporated into the second and fourth year student financial aid budgets; and be it further

RESOLVED, That the AMA ~~working in conjunction with the Liaison Committee for Medical Education~~, encourage schools that ~~have procedures in place for paying the NBME registration fees~~ to offer the option to students to have these fees included in the tuition statements.

Education of Students on the Hazards of Ultraviolet Radiation (Tanning Rays) (OSMA Am. Res. 60-91)

The AMA House of Delegates **adopted** the following Ohio resolution:

RESOLVED, That the American Medical Association work with the U.S. Department of Education to include in the curriculum appropriate information for teachers to educate their students about the hazards of ultraviolet radiation.

Sample Medication Packaging (OSMA Am. 67-91)

The AMA House of Delegates **adopted** the following Ohio resolution:

RESOLVED, That the American Medical Association request that all pharmaceutical companies distributing medicine samples to physicians' offices voluntarily comply with the request that all sample medications being distributed be packaged in such a way that a blank place be included in the packaging material so that

the physician can write specific instructions on the sample container as to how the medicine should be taken.

PRO — Abuse of Statutory and Regulatory Power (OSMA Am. Res. 29-91)

The AMA House of Delegates **rejected** the following Ohio resolution. Members of the House of Delegates felt that the issue appears to be a local concern and were not convinced that PROs are interfering with medical staff self governance beyond this isolated incident.

RESOLVED, That the PRO not intentionally interfere or inappropriately influence appointments to quality assurance and/or utilization review committees made by hospital medical staff or administration; and be it further

RESOLVED, That the AMA reaffirm the importance of medical staff independence and self-governance pursuant to the terms of the hospital staff bylaws.

Unannounced PRO Enforcement of Regulation (OSMA Am. Res. 31-91)

The AMA House of Delegates **adopted** the following Ohio resolution:

RESOLVED, That the American Medical Association petition HCFA to preclude application of a law, rule or regulation prior to its effective date; and be it further

RESOLVED, That HCFA announce the date on which the enforcement of a law, rule or regulation applicable to the Medicare program will begin.

PRO Physician Advisor Confidentiality (OSMA Am. Res. 32)

The AMA House of Delegates **adopted** the following resolution in lieu of two resolutions, including one from Ohio, on the subject of PRO physician advisor confidentiality:

RESOLVED, That the American Medical Association (AMA) petition third party payors and the Health Care Financing Administration (HCFA) to require PROs and carriers to publish and

forward annually to the quality assurance chairman and the chief of staff of all hospitals under their jurisdictions as well as all state medical associations, the names of physician reviewers, their credentials, and their specialties; and be it further

RESOLVED, That the AMA petition HCFA and third party payors to require that the physician reviewer reveal their identity by signing the letter submitted to a physician placed under review.

Health Access America Credibility (OSMA Am. Res. 22-91)

The AMA House of Delegates changed the title of the Ohio resolution to read "Physician Role in Health Access America" and **adopted** the resolution as submitted:

RESOLVED, That the American Medical Association continue to refine and improve Health Access America to incorporate additional approaches which are consistent with improved access and continued quality, and which reflect physicians' accountability and responsibility in appropriate cost containment.

Osteopathy 100 Year Anniversary (OSMA Res. 70-91)

The AMA House of Delegates **referred** the following Ohio resolution to the **AMA Board of Trustees** for consideration of appropriate recognition:

RESOLVED, That the American Medical Association adopt an appropriate congratulatory message for the American Osteopathic Association on the occasion of their celebration of providing quality health care in America; and be it further

RESOLVED, That the AMA work jointly with the American Osteopathic Association and support American Osteopathic Association members in their petition to the Postmaster General of the United States to issue an American Osteopathic Association centennial commemorative stamp in the recognition of the 100-year anniversary that the American Osteopathic Association has provided quality health care in America.

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ly \$3 million. Minimum requirements are: Graduation from an accredited college or university with a master's degree in public health or a closely related health field, or licensed in the state of Ohio as a physician, dentist or veterinarian; and five years of responsible administrative experience in the planning, development and management of public health programs or other public sector operations. Must possess a valid state of Ohio driver's license upon appointment. Salary range: \$59,252 to \$69,126 annually. Interested candidates should submit a detailed cover letter, resume and a copy of their college transcript(s) to the Department of Human Resources, Selection and Evaluation Section, One Government Center, Suite 1920, Toledo, OH 43604 EOE, M/F/H.

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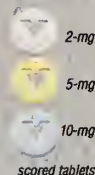
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COVER STORY

Pediatric ophthalmologist and OSMA Fifth District Councilor Ronald L. Price, MD, recently served a mini-internship with the Honorable Gary Suhadolnik, the Ohio state senator from the 24th district. The following article by Dr. Price reveals his impressions of that day this past May when he had the opportunity to sit behind the brass rail. Story on Page 447.

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To Our Colleagues

SOME OBSERVATIONS ON "WOMEN IN MEDICINE" MONTH

September is "Women In Medicine" month. This is the second time the AMA has celebrated women physicians' history and accomplishments. There is a lot to acknowledge about our female colleagues: the number and influence of women

in medical schools, residency training and medical practice continue to grow dramatically. Today there are four times as many women physicians as there were in 1970, and there has

been an overall increase of almost 92% in the last decade.

While male physicians can trace their roots in the art of healing to biblical times, it wasn't until the mid-19th century that women were

accepted for training as physicians. It was to become a century of discovery, challenge and transition for medicine and the men who practiced it.

The 19th century ushered in many scientific advancements: the vaccine for smallpox was discovered in 1842; antiseptic surgery in 1870; and aspirin in 1899. It was also a time when women overcame enormous opposition and obtained medical education and training. By the end of the century, over 7,000 women were serving as physicians in the United States. Their numbers included not only white Protestants, but also (more than 100) blacks, Jews, and members of the (then) immigrant groups.

The American Medical Association (AMA) entered the debate in 1868, shortly after the Civil War. The AMA urged its members to support women's entrance into the profession and to admit them into the association. Five years later, while the U.S. Supreme Court was still allowing states to prohibit women from practicing medicine, the AMA listed women physicians in its membership directory.

By 1880, only a handful of American medical schools accepted women on a regular basis. And many of those limited the number

**Joseph Sudimack,
Jr., MD**
OSMA President



Presidential Perspectives

of female students to four or less per class. So the leading women physicians of that time founded women's medical colleges, and built dispensaries and hospitals to provide clinical training for women graduates. By the turn of the century, women physicians numbered between 4% and 5% of the profession — a figure that remained relatively stable for the next six decades.

Membership in medical societies accorded members special status, economic and professional advantage. The first medical society was founded in New Jersey in 1766. Others followed, including the (national) American Medical Association in 1846. But the one element they all had in common at first was their refusal to admit women physicians.

Women therefore founded and generally joined all-women's groups they established, not to compete but to run parallel to the male medical societies upon which the groups were modeled. The American Medical Woman's Association was founded in 1915.

Gradually medical societies began to recognize the professional quality of the women physicians who petitioned for membership. In 1877, Kansas, Rhode Island and Michigan became the first state medical societies to open their doors to women. By 1881, 17 state societies accepted women as members.

But acceptance of women physicians by hospitals was not easily won. In 1925, 50% of all women interns were trained in nine hospitals — which were mostly owned and operated by other women. Today, all hospitals accept women physicians as interns and members of the medical staff.

The advances of women physicians was one of the best-kept

secrets until the first half of the 1970s when young women decided that they had a place in medicine. Soon the number of women applying to medical school quadrupled. By 1989, women comprised more than 38% of the students entering American medical schools, compared to only nine % 20 years earlier.

In 1989, women were 29% of all residents. The specialty choices that women and men make in pursuing their residency differ sharply, however. According to a recent survey, two-thirds of women in residency training are found in five specialties: internal medicine, pediatrics, obstetrics/gynecology, family practice and psychiatry. Even though less than one-third of all residents are women, in 1988, women comprised 49% of the residents in pediatrics; 46% in ob/gyn; 39% in psychiatry; 51% in child psychiatry; and 44% in dermatology. In contrast, only 12.5% of surgical residents in 1988 were women.

Arnold Relman, MD, editor-in-chief of the *New England Journal of Medicine*, wrote in 1989 that "A changing younger profession, more broadly representative of American society, with more moderate income expectations and a greater commitment to the primary care specialties, will be in a better position to meet the needs for health care in the next century." The advent of women in medicine is helping to create that future.

In some respects, the increasing participation of women in medicine has led to increasing similarities between the practices of women and men physicians. However, some important differences remain, differences that are not likely to disappear in the near future. The continuing clustering of women in the

primary care medical specialties is a good example of what may not change.

The statistics on women in medical schools and residency programs suggest that as the physician population ages, it will become increasingly female. However, males still outnumber female medical students by a large margin, so it is difficult to predict when or if they may ever become a majority of the physicians in the United States.

We need more women in medical societies. We must take steps to increase their involvement in our society as physicians and medical students. We need the balance of their dedication and involvement in professional activities. We need their perspectives — as both physicians and as women in medicine — to further the development of health-care policy and the medical profession. It is time for women to become an integral part of the mainstream medical community. **OSMA**

Ethics in Medicine

FACTORING IN THE PATIENT

A recurrent theme throughout the history of medicine distinguishes our profession: ethics. And throughout our long history, the recurrent, overriding question in any ethics dilemma has been, "What is in the patient's best interest?"

Of course in the past there were

peculiar interpretations of ethics questions. There was Hippocrates' now-quaint prohibition of pessaries. The AMA in Woodrow Wilson's day considered health insurance an unethical, ungodly

experiment in socialism. And in the '30s, the AMA cast into perdition any physician who worked for a health maintenance organization.

Peculiarities? Yes, but they were reflections of their times, and, given that context, were perfectly

reasonable ethical pronouncements.

The point is that the principles of medical ethics are not absolute. Like the Ten Commandments, interpretations change with the spirit of the times, but the welfare of the patient must always be factored into the equation.

In the '70s and '80s as new medical discoveries proliferated, competition among pharmaceutical companies for the attention of physicians intensified. Simple educational events became elaborate excursions. In the race for physicians' favor, pharmaceutical companies enticed physicians with increasingly costly travel and entertainment events. And as the value of inducements to attend functions escalated, the participants became jaded.

The evolution of these programs was natural and, given the temper of the times, predictable.

Now, the medical-industrial alliance has become so intertwined that Congress threatens to investigate this symbiotic relationship. It was only the timely appearance last December of the AMA's guidelines on gifts to physicians that forestalled an investigation by Sen. Edward Kennedy (D-Mass.) into pharmaceutical promotion methods. Sen. Kennedy's interest was kindled by such tidings as the *New York Times'* report that gauged 1990 marketing

By Wilma
Bergfeld, MD



Guest Editor

expenditures by pharmaceutical manufacturers at an average of \$5,000 per physician.

This level of expenditure must be viewed with concern. The profession cannot tolerate even the suspicion that anything but the welfare of the patient influences a physician's decision. For that reason, the Board of Directors of the American Academy of Dermatology endorsed at its earliest opportunity the AMA guidelines on gift-giving to physicians. The guidelines forbid accepting anything more than a nominal dollar value from a pharmaceutical company unless it is earned as a faculty member, consultant or speaker. The ruling prohibits payment for appearing at dinners, meetings and cruises.

Anyone who had followed the actions of the academy for the past four years was not surprised by its endorsement of the AMA guidelines. In 1987, to assure that commercialism did not creep into the academy's public service announcements, films and other public relations materials, the board approved guidelines governing their production. Following that initiative, the board in 1988 approved guidelines for industry cooperation in the development of academy educational programs and services.

Three years ago the academy began requiring all its leaders — officers, the Board of Directors, committee chairs and senior staff — to file disclosure of potential conflict of interest. Faculty at the Annual Meeting and speakers at the annual business meeting are also expected to declare possible conflicts of interest. Detailed information is not required, only disclosure of interest in a corporation, consultancies, research grants and other relevant

associations.

Central to all these guidelines is the desire of the American Academy of Dermatology to remain at arm's length with industry. Credit, of course, should be given to industry for its generous support of educational programs. But that credit should not extend beyond the simple statement that a program is supported by an educational grant from the XYZ Corporation.

These are the ethics of the '90s. But is their intent any different from what medical ethics have always been? Patient care and the effect on that care of any ethical interpretation is the basis for all of the academy's ethics judgments

and of the seminal AMA "Gifts to Physicians" guidelines.

The hallmark of a profession is its ability to maintain high ethical standards through a system of self-regulation. We must not relinquish this responsibility, but must protect it by rigorous adherence to the ideals of the profession. **OSMA**

Wilma Bergfeld, MD, Cleveland, is the President-elect of the American Academy of Dermatology, Past President of the Ohio Dermatological Association and of the Academy of Medicine of Cleveland.



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Are City Sun Parlor

Editor's note: Two physicians debate the issue of the recently passed Toledo ordinance on sun tanning facilities.

DOESN'T STATE LAW

SAY IT ALL?

**By Craig G.
Burkhart, MS, MD**

For the record, I strongly oppose the Toledo ordinance on sun tanning facilities passed as an emergency measure in May 1991. This in no way prevents me from strongly supporting the legislation in Ohio law on sun parlors, which ensures good standards for the installation, operation and maintenance of tanning equipment.

To understand this apparent contradiction, one begins with an analysis of the two laws. Although Toledo's ordinance reiterates a few themes also found in the Ohio law, there are four differences I note:

- (1) The Toledo law requires goggles that block out *all* ultraviolet (UV) light, whereas the state law requires 99.9% of UVB and 99% of UVA light. No goggles block 100% of UV light.
- (2) The Toledo law also regulates physicians' offices in which UV light is utilized.
- (3) The Director of Health in Toledo's law has significant



Craig G. Burkhart, MS, MD

powers to interpret a vague ordinance. The Ohio law clearly delineates the rules.

- (4) The Toledo law requires the testing of sun lamp efficiency. Given our present technology, the variance of UV light meters (or radiometers), and the various types of light beds and bulbs, reliability of such testing is not adequate.

Neither statute regulates other sources of obtaining UV rays, such as retail sun lamps, lights at spas, or the most popular UV source, the sun.

Turning only to the Toledo law, what benefit does it have for Toledo? It doesn't restrict anyone from going to a sun parlor. Some argue that it would allow better enforcement of tanning regulations

— Hamilton, Ohio has had an identical law for two years and has yet to begin any action to enforce any of its contents. Some say the law would increase public awareness of the hazards of UV light, but there is nothing in the law to do so.

The Toledo law has been estimated to cost between \$30,000 and \$60,000. In a city cutting back on police, education, firemen, rat control, and the testing and abatement of lead levels in children, why are we so worried if the lights in sun parlors are bright enough?

In terms of sun parlor regulations, what is wrong with the Ohio law, as well as the F.D.A. requirements, on the equipment? One could require tanning salons to have malpractice insurance, which also has requirements for these tanning businesses.

In conclusion, there are better ways to educate and serve the public about UV light exposure than these city laws. Australia and Denver, Colorado have had excellent results with the public education of the "Slip, Slap, Slop" theme: Slip on a shirt, Slap on a hat, Slop on sunscreen. The American Cancer Society of Lucas County will be initiating such a program next fall thanks to my initial contribution of \$5,000. **OSMA**

Craig G. Burkhart, MD is a dermatologist practicing in Toledo.

Second Opinion

Ordinances Necessary?

THERE IS NO
SUCH THING
AS OVERREGULATION

By John P. Anders, MD

In no way did the recently passed city ordinance regulating tanning parlors in Toledo supercede the state law. It augmented it. The tanning parlor issue is a major public health concern and if addressed, can be a very cost-effective preventive medical measure. Dermatologists know the hazards of excessive ultraviolet light. These "tanning machines" are not toys — there can be no such thing as overregulation.

Testing for UVA radiance is possible. Testing of UVA bulbs is very feasible and was added to the legislation on the strength of consultation with a University of Michigan physician who directs photobiological activities, and further consultation with the International Light Corp. of Newburyport, Massachusetts.

Regarding the concern that physicians' UVL units could be regulated if the city ordinance passed — I know of no Toledo



John P. Anders, MD

physician who uses a UVL machine as a *tanning facility*. According to the *Skin Cancer Foundation Journal* (Vol. VIII, 1990, page 62); "Tanning and phototherapy devices are two distinctly different devices under the FD&C Act. A phototherapy device is a prescription device intended for the treatment of medical conditions which require the diagnosis and care of a licensed health care professional."

The misuse of tanning parlors is a basic public health issue, and education of the public on UVL hazards is extremely important. One can catch much more than a tan from a tanning bed. One can also catch herpes, warts, lice, impetigo, scabies, ringworm, etc.

OSMA's passage of Resolution 60-91 will help because it calls for curriculum changes through the Board of Education concerning UVL. The enforcement of this ordinance has its place in any city's priorities along with education, fire and police protection, rat control, and protection of children from lead poisoning. Who can question the wisdom and importance of protecting the public from cancer? The potential savings, in human and financial terms, are enormous.

Working on the passage of Toledo's city ordinance was a great learning experience. It proved that organized medicine can be effective in influencing legislation helpful to communities. Such was the case also for our legislative model, Hamilton, Ohio, where dermatologist Lou Barich, MD, assures us that city does inspect its tanning parlors.

The cooperation of government, physicians and the media was encouraging. We proved decisively that we can work together, and we look forward to doing so again.

John P. Anders, MD is a dermatologist, practicing in Toledo and President of the Academy of Medicine of Toledo and Lucas County.

Letters to the Editor

The real cause of infant mortality

To the Editor:

Recent attention to the infant mortality rate of the United States has created an erroneous impression that American medicine is inferior to that of other countries. Our higher infant mortality rate than some other countries has been cited as evidence of the poorer quality of medicine at a higher cost in the United States. This has been especially promoted by those who advocate some form of universal government health insurance.

The problem of infant mortality is a social problem, not a medical one. The leading cause of infant mortality is the high prematurity rate in infants born to teenage mothers of low socioeconomic and limited educational level. Many of the problems relating to infant mortality are associated with the intake of drugs, inadequate diet, unhealthy lifestyles. In fact the medical care of the premature infant in the United States is very sophisticated, and today small babies weighing less than one and one-half pounds with respiratory disease are being saved, when only a few short years ago they would have all died. The very sophisticated intensive care units of our hospitals, including the very excellent ones in our city, has greatly increased the chances of premature babies surviving. These treatments require expensive state-of-the-art medical care. The problem of the infant mortality therefore is related to the social situation leading to a high prematurity rate. In addition other factors to babies born of mothers addicted to drugs, and mothers whose inadequate nutrition results in babies having inadequate nutrition in utero are causes of

high infant mortality rates.

In addition the calculation of the infant mortality rate as recommended by the World Health Organization is not standardly adhered to by all countries. The World Health Organization also does not test and check to see if these recommendations are followed, e.g. the Soviet Union will not report as an infant death a baby born below a certain weight. In Japan infants were not considered to be listed in the statistics until they were one year of age. Many infants who weigh 500 grams, which is barely one pound, and subsequently die in a few minutes after birth, are listed as infant mortality statistics in the United States and not in other countries. We are, therefore, not comparing like statistics, and therefore this is another area in which a false impression of the infant mortality rate in the United States is given.

It is the responsibility of all our citizens to improve the general welfare of our citizens. Our infant mortality rate, which was in 1960 about 26/1,000 and is now approximately 10/1,000 is a tremendous reduction. The continuing infant mortality is related to the above mentioned social situations and not due to lack of quality pediatric care in the United States.

Arnold B. Friedman, MD
President, Ohio Chapter American Academy of Pediatrics

Another look at the ER

To the Editor:

The report, "A biopsychosocial profile of the geriatric population who frequently visit the emergency

department," which appeared in the July 1991 issue of *OHIO Medicine*, is well written, addresses a significant medical and medicosocial problem, and is an appropriate winner for OSMA's writing contest. What follows is a criticism not of the paper but of the contemporary medical environment in which the study was necessarily done.

New techniques for the management of biological diseases are rapidly adopted in the American health care system, but advances in comprehensive care of ill people are not. The cited manuscript could just as easily have been written 35 years ago from the old Receiving Ward at the Cincinnati General Hospital, where I was then a student. The word "biopsychosocial" appears in its title, but there is no information about social support systems beyond a bare mention of marital status. Neither do we learn anything about the persons behind the 16.6% of "somatic" chief complaints (these deficiencies were probably inevitable in a chart audit from an Emergency Department).

If society really wants to do something about the high cost and inappropriate nature of a significant part of our health care, some good places to start can be inferred from the report of Brokaw and Zarea: Provide adequate payment for Medicaid and Medicare office visits so that physicians will more willingly care for these patients. Staff emergency departments with strong social service units that can give isolated, dysfunctional patients the information and referrals they need to function better, so that they will be less likely to keep returning to the ED inappropriately. Finally, restructure medical schools and residency programs so that future physicians are exposed to models of patient care that are

Letters to the Editor

not only of high technical quality but also involve an understanding of the totality of illness and its relation to what goes on in the world outside the doors of our educational institutions.

Robert D. Gillette MD
Youngstown

An open letter to OSMA members

Dear Doctors:

I am a mother writing on behalf of all our children in medical school. Our children graduated in the top 10% of their class in high school, they were in the top 10% during their college years, and were admitted into medical school. They are intelligent, caring and compassionate. They work very hard to achieve their dreams.

But they found out that intelligence and hard work are not enough to get through schools of medicine. They have to measure up to the very high standards set upon them by the school. The standard varies from college to college, and it doesn't even guarantee that the students will turn out to be good doctors in the future.

No matter how hard the students study, how many endless hours they spend attending classes, lectures and laboratories all day and into the night, they are still unable to measure up to school standards. They dread examination time, get depressed after the exams, and in a few minutes, a select committee can crush their dreams and destroy their future.

As parents, we can only contribute to their financial responsibilities; we can only lend moral support. We worry with

them, cry with them and pray for them. We wish we could do more.

We do have a few questions to ask of you, as members who will ultimately determine our children's future. When you accepted our children to your school program, we all accepted responsibility — the students to study hard, the parents to provide financial as well as moral support. But what of the school? What is their responsibility?

What do you do for those who don't measure up to your standards? Why do medical school standards differ from one college to another within the same state?

As soon as students are accepted to your program, didn't you assume the responsibility of seeing to it that all students are given the opportunity to graduate — even if that might take longer than usual?

Have you looked back and determined what happened to all of those who did not measure up to the school's standards? Do you have any programs available to those who will not measure up?

Maybe it's time that we, the parents, are provided more information about our children's progress, about medical school standards, before you make decisions. What if the student in front of you — the one who doesn't measure up — is your own child?

From a concerned mother

Editor's note: *Deans at each of Ohio's medical schools were asked to respond to the letter printed above. Four schools responded by deadline. Their letters follow.*

Wright State University School of Medicine

The decision to accept an applicant to medical school is a commitment to provide every opportunity for success. Students who experience academic or personal difficulties have several options including reduced schedules, free tutoring services, study skills assistance, and personal and financial counseling. At Wright State University School of Medicine students with academic problems have a two-week period at the end of each quarter to remediate courses. Other schools provide remediation opportunities in the summer months. In many departments, faculty offer additional small-group review sessions to help students master the subject. All teaching faculty offer individual assistance to students who seek help. Increasingly, schools offer review courses in the second year to assist student preparation for the National Board Part I examination.

Students in medical school are a select group — they work hard, are highly motivated and take advantage of the resources offered them. Only a small percentage of students, 3%-4% nationally, are dismissed or withdraw for academic reasons. At Wright State University School of Medicine we are interested in graduating humanistic physicians. We do more than teach a humanistic orientation. We have an obligation to treat each student fairly and with compassion while we maintain high academic and humanistic standards — we practice what we teach.

Paul Carlson, PhD

Associate Dean for Student Affairs and Admissions

Letters to the Editor

Ohio State University College of Medicine

The letter from a concerned mother of a medical student is obviously a thoughtful one. It is true that medical students are the outstanding young people in the nation coming to us from high schools and the undergraduate universities. Most are interviewed carefully for assurances that they are caring and compassionate and, of course, are evaluated for their scholastic achievements. It is also true that there is a great deal to learn in medicine, and it is a difficult course of study. That has always been the case because the public, our fellow citizens, have entrusted us to care for their spouses, children, grandchildren, and all of their loved ones. Therefore, in a relatively short time the medical students must learn as much as humanly possible in order to perpetuate that trust and, importantly, to provide the very best care that humans are capable of providing in 1991.

Fortunately, almost all of the medical students who enter colleges of medicine are able to graduate within four or five years. Only a very small percentage decide that a medical career is not for them and leave voluntarily. An even smaller percentage of the students find that a medical education is simply too demanding or too difficult and they do not pass the required curriculum. Faculty members in the colleges of medicine are dedicated people and take it quite seriously to teach the students and help them to remediate courses in which they have difficulty. I think the concerned mother raises an excellent point about providing more information about the student's progress in medical school and even the standards and

expectations that the medical faculty have. The letter is valuable in that it draws attention to the difficulty of the course of studying medicine as well as our need to provide appropriate information to all concerned parties.

Manuel Tzagournis, MD
Vice President for Health Services
Dean, College of Medicine

From Case Western Reserve University School of Medicine

One cannot help but be touched by the pain and concern shown in her letter. Precisely the same type of concern was one of the major factors leading the faculty of Western Reserve University (as it was called at the time) to push forward a revolution in medical education in 1952. From that time, we have held, as one of the most important elements of medical education, that students should be regarded as "junior colleagues" and that they should be treated with respect and humanity so that they would treat their patients in the same way. I think that there has been a growing awareness in medical schools around the country of the educational benefits of a supportive atmosphere, and current curriculum reform efforts often contain such elements.

High standards for students of medicine are essential because of the complexity and promise of the arts and sciences that the students must master, as well as because of the high responsibility for the care of others. However, faculties make a serious mistake when they feel that severity of demands and demeanor are essential for outcomes of high quality. Learning medicine will always be a

demanding task, but we as teachers have an obligation to our students to assist them in these tasks with dignity and respect.

While the competition for admission varies somewhat from one school to another, the accreditation process ensures that the basic standards of expectation of the schools for their graduates are generally equivalent. Schools do vary in their ambience and in their methods, and any given student may find himself or herself better suited to the environment at one school than at another. It is very important in choosing a school to visit and talk with enrolled students about the feel of the place.

Virtually all students admitted to accredited American medical schools are intellectually capable of mastering the knowledge base required to be effective physicians. In some cases extra time may be required, and in some cases students find that their motivation is not deep enough for the challenges. Most modern schools of medicine do have academic support mechanisms and personal counseling systems in place to assist students in tapping their abilities, although I am sure that all of us could do a better job.

Neil S. Cherniack
Vice President for Medical Affairs
and Dean

Letters to the Editor

University of Cincinnati College of Medicine

The letter from a concerned mother expresses some of the emotions and frustrations which many of us have experienced at some time as parents, and can be easily understood and appreciated. The underlying issues that are raised that apply to medical education have been of concern to faculty and administrators for some time and are recognized as being serious issues that must be dealt with in a number of ways.

The educational responsibility of medical schools involves the preparation of students who will practice medicine well into the next century utilizing technology and knowledge that will far exceed what is currently available. Not only must students learn the science and art of medicine as we know it today, but learn how to prepare themselves for a profession that is rapidly evolving and will continue to change throughout their career. Society expects that each physician will provide medical care to the best of his or her ability. Medical students accept this societal expectation as a personal commitment that they make for their profession and approach their studies accordingly. Considering the complexity and volume of medical knowledge, the emotional adjustment that students must make as they deal with issues of illness, pain and death, and the concomitant development of a sense of professional responsibility toward their patients, it is no wonder that so many students experience episodes of stress during their medical education. In addition, it should not be forgotten that the medical student is also confronted with a cost of medical education which increases throughout the four medical

school years while financial aid programs continue to have a diminished impact on escalating indebtedness. The student is well aware that public policy is not directed today toward relieving the financial burden that graduating physicians will carry into their practice.

In response to sources of stress which are endemic in medical education, the University of Cincinnati College of Medicine has maintained a high level of sensitivity to the needs of its students and has actively sought ways to create a positive and supportive learning atmosphere. A wide range of both personal and academic resources have been developed to meet differing student needs. A supportive faculty is available to discuss students' concerns and questions and to offer help. An experienced Student Affairs Staff is available to provide academic and personal counseling and to identify additional resources which might be of benefit. Faculty advisers are assigned during the first year and serve as a mentor and liaison throughout the four years of medical school. Tutors are available to each student along with a Learning Effectiveness Program which provides individualized assistance designed to improve learning skills. Other sources of support come from support groups specifically designed for first- and second-year students, a peer counseling organization, and stress management workshops. Spouses/significant others are included through a special orientation program and a couples organization. An extensive financial aid program has been developed to assist students in maximizing their resources and in managing their debts.

While many sources of stress have not been eliminated, students

have available professional assistance and guidance in ways to deal with situations that if not properly attended can be extremely difficult. Despite the difficulties that compound medical education today, most students experience great excitement in their medical education and begin to experience the personal satisfaction that comes from the practice of medicine.

J. Robert Suriano, PhD

Associate Dean for Student Affairs
and Admissions

Dorothy H. Air, PhD

Assistant Dean for Student Affairs

OHIO Medicine

welcomes Letters to the Editor.

Executive Editor

OHIO Medicine

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Association News

Medicare seminar may provide answers

Confused by Medicare's miles of red tape? Tired of making costly errors that slow the reimbursement you receive from Medicare? Unclear as to exactly how Medicare's prospective payment system, which it plans to implement in January, will affect your practice?

If your answer to even one of these questions is yes, you or your staff may want to check out the series of one-day workshops, "Medicare Update: How to Do it Right," which the OSMA is sponsoring this month in conjunction with Conomikes Associates, Inc.

The workshops will not only provide you with the answers you need to reduce errors and improve your reimbursement, but it will also explain how Medicare's new payment system will determine the relative value of a procedure or service and what components of the payment will be.

Dates and locations for the seminars are as follows. If you would like more information on these workshops, contact the OSMA Department of Educational and Administrative Services at (800) 766-OSMA.

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September 11 — Canton
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September 25 — Dayton
September 26 —
Springdale/Cincinnati. **OSMA**



Outstanding Service

Jerry Campbell, an OSMA associate executive director and director of the Department of Development and Member Services, was recognized for his 25 years of outstanding service to the physicians of Ohio at the OSMA Annual Meeting in May. Herb Gillen, right, presents a plaque to Campbell and his wife, Bobbie. The House of Delegates recognized his service with a standing ovation.

OSMA establishes PRO meeting

In an effort to establish better communication with Ohio's Peer Review Systems, Inc., the OSMA Ombudsman staff has been meeting with members of the PRO executive staff.

"We came up with this idea because of the great success we've had over the years with meeting on a regular basis with Medicare," says Bill Fry, director of the Department of Professional Relations and Ombudsman Services. Everyone involved is delighted with the process, he says. "It's a way to keep them updated and for them to update us," Fry says. He points out that PRO issues are not day-to-day issues like Medicare, so meetings are not held monthly.

By setting up meetings every few months with PRO, Fry points out that it "forces us to meet, to communicate and to get things done."

The most recent meeting, June 27, which was the third such meeting this year, dealt with quality screens for skilled nursing facilities, psychiatric, inpatient and home health. These screens are made available at the various seminars, as are reports on the physician adviser thought process, and common problems identified through PRO review.

Those in attendance included members of the Ohio Osteopathic Association, Ohio Hospital Association and OSMA.

The next meeting is scheduled for October 3 at the Ohio Hospital Association. **OSMA**

Association News

Five OSMA members hold AMA posts

Five members of the Ohio State Medical Association were appointed or elected to positions in the American Medical Association at its annual meeting, held this past June in Chicago. They include:

- Oscar W. Clarke, MD, Gallipolis, chair of the AMA Council on Ethical and Judicial Affairs.
- Richard M. Steinhilber, MD, Cleveland, re-elected to the AMA Council on Scientific Affairs.
- Herman I. Abromowitz, MD, Dayton, chair of the Organization of State Medical Association Presidents.
- Jane Uva, Dayton, Wright State University medical student, elected to the AMA Medical Student Section Governing Council.
- Edmund W. Jones, MD, re-elected to the AMA's Hospital Medical Staff Section Governing Council.

John E. Albers, MD, Cincinnati, will be a candidate for the AMA Board of Trustees at AMA's Annual Meeting next June. **OSMA**

OSMA survey polls members on universal health

What do Ohio physicians think about the changing health-care delivery system? Should the state move toward or away from a universal health-care system? What other options are there?

This past July, the OSMA sought to find answers to these

questions and others by conducting a telephone survey of a random sample of Ohio physicians. The survey, conducted by the Gallup organization, was funded by the American Medical Association.

Survey results will be published in a future issue of *OHIO Medicine*, as well as by other OSMA publications. The information will be used to help the OSMA determine how to better motivate physicians to participate in this important health-care issue.

In the meantime, the association, through its Department of Communications, is actively involving physicians as both speakers and interviewees on the subject of universal health. This summer, for example, OSMA speakers addressed the subject at a meeting of the Ohio Municipal League and at district hearings sponsored by U.S. representatives Dennis E. Eckart (D-Mentor) and Ralph S. Regula (R-Canton).

Don't forget the Department of Communications has published brochures that attempt to educate your patients on the subject of universal health. To order a supply for your office, contact: OSMA, Department of Communications, 1500 Lake Shore Drive, Columbus, OH 43204-3824. **OSMA**

Continuing Medical Education

DRGs, abortion headline this year's Fulton lecture

"The Moral Aspects of DRGs" and "How Not to Argue About Abortion" are the two topics to be presented this year at the Eleventh Annual Richard L. Fulton, MD Memorial Seminar. Carl Cohen, PhD, professor of philosophy at the University of Michigan, will be the guest speaker.

The seminar will be held at Riverside Methodist Hospitals' Susan H. Edwards Auditorium in Columbus on Tuesday, October 8. "The Moral Aspects of DRGs" will be presented at 7:30 a.m. "How Not to Argue about Abortion" will follow at 8:30 a.m.

The Fulton Memorial Seminar commemorates Richard L. Fulton, MD, a past president of the Ohio State Medical Association. For further information, contact Leslie Lynch, CME coordinator, Riverside Methodist Hospital, (614) 566-5769. **OSMA**

Prostate and Bladder Cancer

. . . Sept. 6-7 . . . Rhodes Hall Auditorium, Ohio State University Hospitals, Columbus . . . 1-800-492-4445 for information.

New Directions in Vascular Medicine

. . . Sept. 6-7 . . . Stouffer Tower City Plaza Hotel, Cleveland . . . 1-800-338-4721, ext. 605 for information.

Fourth Annual Multiple Sclerosis Update . . . Sept. 13 . . . Hyatt on Capitol Square, Columbus . . . 1-800-492-4445 for information.

Diabetes and Peripheral Vascular Disease . . . Sept. 27-28 . . . Holiday Inn Crown Plaza, Columbus . . . 1-800-492-4445 for information.

Association News

OSMA Ombudsman department sets example

If you haven't heard of OSMA's Ombudsman department, you may well be the only one. Member-physicians from all over the state have learned quickly about the trouble-shooting capabilities of this department, and have acted accordingly. In June, for example, the Ombudsman staff handled 213 member-physician inquiries and an additional 102 requests for hand-out material. Now, news of our Ombudsman department is extending beyond state lines.

This summer, the Pennsylvania Medical Association sent a representative, Barbara Layne, to OSMA's headquarters in Columbus to determine whether or not Pennsylvania might be able to implement a similar program for its members.

One of the items discussed with Layne during her OSMA visit was the Ombudsman's new telephone tracking system. This new, computerized inquiry logging system, implemented last July, was developed by Ombudsman staff member Janet Shaw and OSMA's director of data processing, Joe Dusina. The new system not only records more efficiently the inquiries made by physicians so that the department can produce more accurate daily, weekly, monthly and annual reports, but it also generates mailing labels, expediting the process for follow-up to requests for information.

If you have not yet discovered this department, and the help it can provide you with third parties, you might let them help you with your next third-party problem. Address inquiries or requests for assistance to: OSMA, Ombudsman Department, 1500 Lake Shore Drive, Columbus, Ohio 43204-3824. OSMA

Colleagues

William J. Marshall, MD, Dayton, OSMA Past President, is joining Wright State University's School of Medicine as its associate dean for clinical affairs. He has also been appointed professor of medicine. Dr. Marshall maintains an active cardiology practice in Kettering, and he is director of the Noninvasive Cardiac Laboratory at Kettering Medical Center. Dr. Marshall served as OSMA President from 1989-1990.

George (Barney) Crile, MD, Cleveland, consultant emeritus at the Cleveland Clinic Hospital, has written a book of memoirs, scheduled to be published by the Kent State University Press, for release next fall. The book, titled "The Way It Was — 1907-1987: Sex, Surgery, Treasure and Travel," will be Dr. Crile's 12th book. His other works have featured medicine or travel adventures. This is his first book of memoirs.

Lawrence A. Frohman, MD, Cincinnati, director, Division of Endocrinology, has been selected as 1991 recipient of the Rorer Clinical Investigator Award by the Endocrine Society. The award is presented to a clinical scientist or investigator in recognition of major research contributions related to pathogenesis, pathophysiology or treatment of endocrine disease.

Michael A. Thomas, MD, Cincinnati, an assistant professor in the University of Cincinnati's Department of Obstetrics and Gynecology, has been selected as a 1991 YMCA Black Achiever. Thomas and other honorees were honored at the 13th Annual Salute to YMCA Black Achievers

Banquet at the Hyatt Regency Hotel. Dr. Thomas, a reproductive endocrinologist, has been with the UC Medical Center since 1990.

Ernest L. Mazzaferri, MD, professor and chair of the Department of Internal Medicine at Ohio State University Hospitals, Columbus, has received two separate awards that recognize his contributions to the medical profession. The U.S. Army recently presented him with a Meritorious Service Medal, the second-highest Army award presented to a military individual serving in a non-combat role, for his support during Operation Desert Storm. From December through May, Dr. Mazzaferri, a colonel in the U.S. Army Reserves, provided medical care at Madigan Army Medical Center in Tacoma, Washington. He has also been named Clinician of the Year by the American Diabetes Association — Ohio Affiliate.

Douglas Rund, MD, professor and chair of the Department of Emergency Medicine at Ohio State University College of Medicine, Columbus, was selected president-elect of the Association of Academic Chairs of Emergency Medicine. The association promotes development, research and scholarly activities in emergency medicine.

Gary Birnbaum, MD, Orange Village, graduated magna cum laude from the Cleveland-Marshall College of Law. He was awarded the degree of juris doctor in June.

Brian F. Keaton, MD, FACEP became the 21st president of the American College of Emergency Physicians, Ohio chapter, at its annual meeting this past May.

Association News

OSMA golf tournament

Three physicians received special awards for long service at the 66th Ohio State Medical Golfer Association Tournament held in June at Bent Tree Golf Club near Sunbury, Ohio. George Huston, MD, right of Marietta, played in the event for the first time in 1936 and has missed only a few tournaments in the 55-year span. Brothers Gilman D. Kirk, MD, left, and Robert C. Kirk, MD, center, of Columbus, began OSMGA competition in the mid-1940s and, likewise, have missed few events. David R. Miller, MD, of Bellefontaine shot an outstanding one under par 71 to capture low gross honors. His name will be inscribed on the Richard P. Bell Trophy. William H. Alcott, MD, of Findlay took overall low net with 55. His name will be inscribed on the Dr. Ray Stephens Memorial Trophy.



Team Physician Awards

Three physicians received the 1991 Ohio Outstanding Team Physician Awards during the Ohio High School Football Coaches Hall of Fame Banquet in Canton. From left to right are: Bernard B. Bruns, MD, Cincinnati (LaSalle High School); Delphis C. Richardson, MD, Columbus, Chairman of the Joint Advisory Committee on Sports Medicine; Thomas D. Swan, MD, Cambridge (Cambridge High School); Fred Dafler, Associate Commissioner of the Ohio High School Athletic Association; and L.A. "Pete" Dils, MD, Granville (Granville High School). A total of 112 Ohio Outstanding Team Physician Awards have been presented since the inception of the program in 1975.

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Physician Behavior and the Family

ALL MDs SHARE
SAME UNIQUE TRAITS

At a recent medical conference I attended, a psychologist discussed the professional values and norms of the world of medicine. He listed unique characteristics of physicians, products of medicine's subculture, which shape their values, beliefs, perceptions and personalities during their formative years of

training and in their professional lives. To pass through the ranks and hierarchy of the medical community, one must be willing to behave in accordance with these norms and expectations.

This socialization process results in each specialty using behaviors that are specific to it, i.e., most

pathologists act and behave as other pathologists, most pediatricians act and behave as other pediatricians, etc. The behaviors, whether successful or unsuccessful in achieving an individual's personal goals, are reinforced by other members of the physician community.

Characteristics include:

1. Action-oriented; physicians are "doers" who prefer to be directly involved in their work, seeing themselves as primary interacters in caregiving.
2. One-to-one encounters; they prefer to deal with others on an individual basis, whether this be doctor/patient, doctor/nurse, doctor/family, etc. Studies demonstrate that they prefer to be left alone and are somewhat detached, independent and self-sufficient with little concern about prestige or what others think.
3. Reactive personalities; they are inclined to wait for their clinical services to be needed and/or requested. The patients present themselves or are referred; physicians respond to a need already defined or in progress.
4. Independent problem-solvers; physicians perceive themselves to be the "deciders" in medical/clinical decision

By Joyce E. Penn
OSMA Auxiliary
President



Auxiliary Page

situations with ultimate authority and responsibility. They value their sense of autonomy with responsibility to their patients and their profession. They don't view themselves as subordinate or subservient to others.

5. Patient advocates; they are oriented to the concept that if a patient needs a specific treatment, he should have it. Cost-benefit analyses are frequently seen as interfering with professional prerogatives and responsibilities.
6. Identification with a professional group; a physician will usually state that he is a physician first, and then his specialization, within the larger

professional designation. He identifies himself with a hospital medical staff or physician group lastly, insofar as it allows the practice of his skill and expertise. Physicians do not relate to the concept of traditional "employment" or "unemployment."

When the physician merges his clinical role and his family role, learned behaviors and professional norms and values affect family relationships. These merging roles can enhance or create stress within the family depending on the communication system, shared needs, goals and awareness we have.

The OSMA and OSMA-A are co-sponsoring a medical family weekend, September 27-29, 1991,

at the Ramada University Hotel, in Columbus. Doctor Jerry M. Lewis, noted psychiatrist and author of *"How's Your Family: A Guide to Identifying Your Family's Strengths and Weaknesses,"* will conduct the seminar designed to analyze and strengthen our medical family relationships.

Won't you join us in attending this informative conference? The OSMA Committee on Education designates participation in the meeting as criteria for 13.5 credit hours in Category 1 CME for physicians. CEU authorization for nurses has been applied for through the Ohio Nurses Association. **OSMA**

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September 26 – "An Update of Hepatobiliary Intervention"
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of Radiology, Vanderbilt University

October 24 – "MRI of Meningeal Pathology"
Dr. Alison Smith, Director of MRI,
University Hospitals of Cleveland

November 19 – "Technegas" and "Brain SPECT"
Dr. Zachary Grossmann,
Professor of Radiology,
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Legislation

Will Ohio have health-care reform in '92?

Newsweek magazine pointed out in its June 24 issue that health-care reform is exactly the kind of issue that all of those seeking office in 1992 will take great pains to avoid.

"It's the scariest politics of all," Republican consultant Mike Murphy was quoted as saying, "because there's no easy answer." And when there is no easy answer, politicians could give voice to a *wrong* answer (at least as far as their constituents are concerned) so why take the risk?

The article concludes that, if any national health-care reform is going to take place — it won't be in 1992.

Will Ohio be any different?

That's hard to say.

Health-care reform has been debated at a feverish pitch in Ohio — in fact, the state seems to stand at the forefront, nationally, on the issue in several regards.

First with its universal health bill — House Bill 175. Ohio is not the only state to be considering a move to socialized medicine — 16 other states are wrestling with their own versions — "but Ohio is light years ahead of the others in terms of the quality of its bill and the quality of its debates," says John Van Doorn, director of OSMA's Department of Legislation. In fact, the bill's sponsor, Rep. Robert Hagan, is so well thought of nationally that UHIO may well serve as a model for similar, national legislation that could emerge in 1993.

Now, however, yet another iron has been added to the fire — House Bill 478, a comprehensive health-care reform bill that was introduced this past June by Rep.

Wayne Jones (D-Akron). According to Van Doorn, this is the bill around which all health care reform discussions may revolve in the House this fall — and it's a doozy. The July issue of the *Legislative Bulletin* provided a glimpse of this bill, pulling out those provisions that are of particular concern to physicians. These include:

- prohibiting physicians from balance billing patients for any service, whether covered by Medicare or private insurer.
- setting physician reimbursement at 110% of the amount reimbursed by Medicare.
- prohibiting radiologists, pathologists, anesthesiologists and emergency physicians from billing patients and requiring all these physicians to bill only through a single hospital bill.
- prohibiting physicians from referring patients to clinical laboratories in which the physician has a financial interest (see Legal section, "Fraud and abuse and the physician entrepreneur" for information on the new law, to be enacted in January, which already prohibits this).
- providing physicians with immunity from medical liability when treating without compensation indigent patients in shelters or certain clinics.

By the time you read this, House Bill 478 will have been sent to the House Select Committee on Health Care Reform, chaired by Rep. Barney Quilter. Presently, the OSMA's legislative staff is in the process of analyzing the bill and sharing copies of it with national medical specialty societies for further input.

"OSMA will strongly oppose some of the provisions in House Bill 478," says Van Doorn.

Still, the bill is a very serious attempt at health-care reform here

in Ohio, and there is tremendous respect, both in the House and again at the national level, for the man behind it.

Wayne Jones is a former deputy director of the Ohio Department of Insurance, so his credentials in sponsoring this bill are impeccable. Before he introduced it in the House, he held a series of meetings with the business community, health insurers and health-care providers, including the OSMA, for their input, and despite some of the provisions that threaten to restrict physician income, Van Doorn calls the bill that came out of those meetings and that was introduced to the House this summer a "politically viable piece of legislation."

"Two years ago, this bill would have been viewed as radical," Van Doorn says. Introduction of UHIO has changed that, however. Now, this bill is the middle ground, somewhere between UHIO and the other health-care reform measures that sit in Quilter's committee.

"It's not going to make UHIO go away, though," cautions Van Doorn. Rep. Hagan, along with labor groups and proponents, such as Ohio Citizen Action, aren't about to give up on universal health-care.

"As far as UHIO proponents are concerned," he says, "Jones' bill is simply rearranging deck chairs on the Titanic. It's not solving what they perceive to be the problem."

Yet there's no denying that the Jones bill may well steal at least some of UHIO's thunder in the days to come.

Does either bill — UHIO or HB 478 — stand a chance of passing next year? Will health-care reform come to Ohio before the rest of the country?

"We'll have to see," says Van Doorn. "The '92 election year

Legislation

session will be shorter, as state legislators return home to campaign in new districts — the result of reapportionment.”

That is likely to prevent any real action on health-care reform from taking place in 1992.

“After the ’92 elections, however,” Van Doorn says, “things could move along quickly.” **OSMA.**

More informed consent needed for abortion

By the time you read this, House Bill 108, the “informed consent for abortion” bill, should be law.

The bill, sponsored by Rep. Jerry Leubbers of Cincinnati, was approved by the House and sent to the Senate in July.

HB 108 imposes new requirements on physicians obtaining informed consent from patients seeking an abortion. At least 24 hours before the procedure is performed, a physician would be required to meet individually with a woman to advise her of the nature of the procedure to be performed, its material risks and side effects and the risks and side effects of carrying the pregnancy to term. In addition, the woman would have to be provided with certain other materials, prepared by the Ohio Department of Health, that detail options to abortion, social service agencies available to assist with pregnancy, childbirth and child care, and characteristics of the fetus at specified intervals during gestation. This material would also have to be provided at least 24 hours before the abortion is performed.



Living will signing

Gov. George V. Voinovich (left) and OSMA Executive Director Herbert Gillen shake hands after the signing of the living will bill that became state law July 9. The enactment of Senate Bill 1 marked the end of a struggle spanning more than a decade. The OSMA joined with the Ohio State Bar Association this legislative session, bringing doctors together with lawyers in support of the bill. Next month's OHIO Medicine will contain an analysis of the new law.

The woman would not be compelled to examine it and the physician could choose to disassociate himself or herself from the state-prepared materials.

Passage of the bill, however, does not automatically mean that enacting the legislation will be easy. The parental notification bill, which became law in 1986 and which required doctors to notify a parent 24 hours before performing an abortion on an unmarried woman younger than 18, was quickly challenged by the Akron Center for Reproductive Health. It was tied up in courts until last year, when the Supreme Court upheld it and the law finally became effective.

The same type of legal entanglement could hold up the informed consent bill, and, when the bill was under discussion in the House of Representatives, a representative for Ohio Attorney

General Lee Fisher told a House committee that it could cost the state up to \$1 million to defend the proposed informed consent law. Ohio spent about \$400,000 to uphold its parental notification law. Of course, this is not meant to imply that the informed consent law need not be followed until it is tested in court. As is the case with any law, compliance is required unless a court orders that it be held in obedience, pending the outcome of a legal challenge.

The OSMA has been neutral on HB 108, in compliance with House of Delegates policy, however the Department of Legislation did work on some technical amendments to the bill that addressed the penalty provisions. An amendment was also approved to ensure input from both the OSMA and the American College of Obstetricians/Gynecologists in the medical information to be

Legislation

included in materials prepared by the Ohio Department of Health. **OSMA.**

Cancer registry set for Ohio

It appears that by the time you read this Ohio will finally have a cancer registry. Ohio had been one of only six states, and the only major industrial state, without a statewide cancer incidence reporting system.

The implementation of a cancer registry for Ohio has been long overdue, especially since Ohio ranks fifth of all states in the number of deaths due to cancer-related causes. That all changed in mid-July when the Ohio House, the Senate Health and Human Services Committee and the Senate passed House Bill 213.

It was quite surprising with the current financial position of the state that the Senate would approve the \$500,000 appropriation, but it appears that the importance of cancer and its impact on Ohioans won out over the budget. The \$500,000 budget, pared down from the original \$850,000 figure, will be used to hire staff and purchase needed computer equipment to get the project on its feet, according to Daniel P. Leite, assistant director, OSMA Department of Legislation.

This is a big victory for members of the OSMA Cancer Committee, especially co-chairs Drs. Charles D. Cobau, Toledo, and Jerome J. Stanislaw, Warren, as well as past chair of OSMA's Cancer Committee, William A. Newton, MD, Columbus, and OSMA past president D. Ross Irons, MD, Bellevue. The Cancer

Committee sees this as the first step in implementing its overall Ohio Cancer Plan, points out Robert Clinger, OSMA director of the Department of Medical Society and Member Relations. The OSMA Committee on Cancer began initial action on a cancer registry back in April 1988. Since then the committee, OSMA Department of State Legislation and the Ohio Department of Health have worked closely to make this happen. Dr. Cobau and many others frequented the Statehouse the last few months to testify in support of House Bill 213.

Rep. Katherine (Kate) Walsh of Oberlin also played a key role in the legislation. The attorney's interest was piqued a few years ago when a friend told her she thought southern Lorain County had more than its share of cancer cases. The issue hit closer to home six months later when her 23-year-old daughter was diagnosed with acute non-Hodgkins lymphoma. When two other young people in the neighborhood were also diagnosed with cancer she became suspicious. After talking with the Ohio Department of Health, Walsh found there was no way of tracking down whether or not such behavior was unusual. That initiated House Bill 213.

Now with the population-based statewide cancer registry researchers can identify the geographic "hot spots" for the disease and also its prevalence in various age groups, occupations and races.

As a result researchers will be able to evaluate trends in cancer incidence, target cancer prevention and control resources, provide cancer researchers with information, investigate factors

related to cancer development and control and provide data to interested individuals and organizations.

According to Walsh, "With the collection of this data by the state, Ohio will be in a better position to find and prevent cancer in Ohio citizens in the future." **OSMA**

Ohio Cancer Prevention Plan

- 1) Data collection, surveillance, assessment
- 2) Cancer prevention
- 3) Early cancer detection, screening, referral, follow-up
- 4) Cancer treatment, rehabilitation, support
- 5) Cancer research
- 6) Evaluation of program process and outcome

OSMA wins SRF refund for physicians

Earlier this year, the Ohio Legislature authorized a refund to physicians who contributed to the state Stabilization Reserve Fund (SRF) during the mid '70s. Each eligible physician must file a claim with the Ohio Department of Insurance within 180 days after publication of a notice in Ohio newspapers. As of this writing, the date for publication of that notice is not certain. However, OSMA members will be notified and OSMA will have claim forms available.

The SRF was created in the mid-

Legislation

'70s as a back-up fund to pay excess medical liability claims that the state Joint Underwriting Association fund could not pay. All physicians who practiced in Ohio and carried medical liability insurance coverage during the years 1976-1979 were required to contribute to the SRF. These same physicians are now eligible for refunds. The amount of the refunds will vary depending upon the amount that the physician originally paid into the SRF fund, but they will include interest on the amount contributed. **OSMA**

OSMA expresses gratitude for SRF refund

The OSMA wishes to express its gratitude to Gov. George Voinovich, Ohio Senate President Stanley J. Aronoff of Cincinnati, and Speaker of the Ohio House of Representatives Vern Riffe of Wheelersburg. Without their support the SRF refund would not have been considered. The OSMA also commends Sen. Bob Ney of Barnesville for the important role he played in securing this refund.

While the OSMA was the driving force behind convincing these key officials to return the SRF funds, the OSMA also gratefully acknowledges the assistance of the following organizations in helping to secure the return of the SRF funds: Physicians Insurance Company of Ohio; PIE Mutual Insurance Company; the Ohio Hospital Insurance Company; the Ohio Hospital Association; the Ohio Osteopathic Association and the Ohio Podiatric Medical Association. **OSMA**



Dr. Devany testifies

John A. Devany, MD, OSMA's immediate past president, recently testified on House Bill 65 — mandatory Medicare assignment — before the House Select Committee on House Care Reform. The OSMA is actively opposing the legislation.

Data bank may reduce cases of child abuse

Cases of child abuse could be reduced if the names of habitual child abusers and molesters are filed into a central data bank that employers could consult *before* hiring prospective child-care workers.

At least that's the idea behind a bill recently introduced into the U.S. House by Ohio Rep. David L. Hobson (R-Springfield). The theory is that child abusers who are caught simply move someplace else to repeat their patterns. The bill, however, would allow police and other law enforcement agencies to retrieve child-abuse information from the National Crime Information Center data bank in Washington, D.C. for schools, day-care centers and other groups that work directly with children. Those groups seeking

information from the data bank would have to obtain a waiver from the individual in question, but as Lt. Gov. Michael DeWine points out, if individuals refuse to sign a waiver — “you just don't hire them.”

The data bank check is supposed to end those tragic stories of reportedly upstanding citizens who use youth organizations to get close to children, then victimize them. Although 94% of convicted abusers repeat the crimes, only 22 states require any kind of record check for prospective child care workers. Ohio requires no statewide or national record checks on employees, but, at present, a lack of coordination between states makes this information difficult to obtain in any case. Hobson's measure is under review in the U.S. House Judiciary Committee. **OSMA**

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- D.** Statewide seminars on issues and procedures;
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- F.** Availability of an electronic claims submission network, to streamline office efficiency;
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Cover Story

Last May, the Honorable Gary Suhadolnik, the Ohio state senator from the 24th district, served a mini-internship, sponsored by the Academy of Medicine of Cleveland, with pediatric ophthalmologist and OSMA Fifth District Councilor Ronald L. Price, MD. Following his internship, Sen. Suhadolnik invited Dr. Price to serve a one-day internship with him in the Ohio Senate. The following article by Dr. Price reveals his impressions of that day this past May when he had the opportunity to sit behind the brass rail.



Confessions of a Legislative Intern

24 Hours — More or Less — in the Ohio Senate

By Ronald L. Price, MD

**Tuesday, May 14
9:00 P.M.**

My internship began at the Galleria Tavern. This isn't a fancy TV-sports, low-lights-and-music, disco-dancing bar. This is a BAR, a classic, smoke-filled, scotch-bourbon-and-beer bar, and, I quickly learned, the "third chamber" of our Legislature. The place was packed with senators, representatives and the ubiquitous lobbyists, but party distinctions seemed to blur under the mellowing influence of the alcohol. There was a sense of camaraderie here, but also the unmistakable aura of power. I was particularly struck by the tremendous respect for the Speaker of the House, Vern Riffe, and the President of the Senate, Stanley Aronoff. The power of these two individuals cannot and should not be underestimated.

Discussions here were wide-ranging, at times reminiscent of all-night, philosophical bull sessions in college. Here, however, the bull sessions were trying to influence decisions and votes. The surroundings at the Galleria may be simple, but the business is most serious.

Considerable discussion that evening involved two issues pending before the Legislature — the Clean Air Bill and the governor's budget. The Clean Air Bill pits mine owners mining high-sulfur coal against industry that wants to burn low-sulfur coal — coal that would have to be imported. Jobs. vs. economic necessity. On the surface, this appears to be a classic lose/lose situation, but I cynically suspect that the only real losers will



be the taxpayers of Ohio.

The educational aspects of the governor's budget were the topic of a separate discussion. Education vs. social reform. Although this has the potential of being a win/win situation, sufficient

monies must first be found. Perhaps, if there was less attention paid to utility, corporate and mine profits, the state could find sufficient money to fund both the necessary educational and social programs.

**Wednesday, May 15
7:30 A.M.**

We began with a breakfast meeting hosted by the Ohio Speech and Hearing Association, similar in style to the OSMA Auxiliary's annual "Day at the Legislature" luncheon. After having attended this reception not as a host but as a guest, I have a great deal of

respect for our representatives who do this repeatedly. This is hard work. My advice to anyone who may be planning future OSMA-A legislative receptions is this: If there are speeches, keep them mercifully short.

8:15 A.M.

We left the reception to go to the senator's office. The senator had told me that nothing was to be held back or hidden from me, since I had shielded nothing from him during his internship. The first thing that struck me in his office was that we need not worry about the Ohio Senate wasting our tax dollars on palatial surroundings. The Senate offices in the Capitol Building have no windows and are crowded into nooks and crannies, with corridors so narrow that if our hospitals tried to use such hallways they would immediately be shut down as fire hazards. (In fact, there was a fire alarm while we were in the

senator's office, but it was, fortunately, a false alarm.)

The second thing I noticed was the information overload. All of us complain about the number of journal articles and reading materials that cross our desk, but I assure you, the senator's desk looked as bad as mine has ever looked. I will never again complain about the weekly news clippings mailed to me by the OSMA. The senator gets four times as many information packets every day. Additionally, he is inundated with bills, substitute bills, summaries of bills, analyses, letters, memos, telephone requests, etc., etc.

9:00 A.M.

We left the senator's office to join one of his committees — the Senate Finance Committee. The room was filled with employees of

the Executive Branch, but there were no fireworks during the meeting.

9:30 A.M.

From 9:30 'til 10:00, we returned to the senator's office to consult with his staff concerning pending legislation and to attack the stack of mail. At 10:00, the senator was visited by a lobbyist — an intriguing experience for me. Previously, *I* had been the one in

the lobbying position. Now I was on the receiving end of the conversation. What occurred, I was surprised to see, was information-sharing. Advice and suggestions were given and received on both sides — a truly educational exchange.

10:30 A.M.

We attended the Energy, Natural Resources and Environment Committee of the Senate, chaired by my legislative mentor. During that hearing, I was privileged to sit on the dais behind the senator, and he repeatedly provided me with both bills under discussion and comments concerning the speakers. I have attended committee hearings sitting in front of the dais, but sitting on the dais,

looking down on the audience as a legislator does, gave me a tremendous feeling of power. It was almost palpable.

The committee meeting ended at noon. Over lunch, our discussions focused on the workings of the Senate, and the value of testimony before the various committees. I learned that, although testimony is essential, it is probably less effective than one might think.

1:30 P.M.

The meeting of the Senate scheduled for 1:30 began promptly at 2:00. Thanks to the consideration and kindness of Senate President Stanley Aronoff, I was permitted to sit inside the "brass rail" — sacred territory, I discovered, as a senator's vote is only recorded if he or she is within that brass-bound boundary. Once again, the sense of power was both intoxicating and addicting. I began to understand the attractiveness of public office.

Throughout the debate, the

senators walked around the room, talking to one another. This isn't considered rude, I was told. Rather, it's the only time all of the senators are together in one room. These meetings afford, then, the best opportunity for conducting business — including garnering support for individual pieces of legislation. All 33 senators were present during the session. Rarely, I was told, are senators absent from the general sessions.



3:00 P.M.

From 3:00 to 3:30, we returned to the senator's office to answer phone calls to constituents and state employees. The senator himself actually had little or no power over the state bureaucracy,

but could exercise power by knowing who best to call to solve a particular problem. I've learned the same tactic works at the OSMA.

3:30 P.M.

From 3:30 to 5:00, we attended the Health and Human Services Committee, chaired by the Honorable Grace L. Drake, senator from the 22nd district. There was some joking and banter between Democrats and Republicans. On the surface, it appeared to be friendly, but from closed-door conversations, I learned that this

was deadly serious business. Legislators do not joke any more about legislation than we joke about the practice of medicine. You may not always like and agree with what legislators do, but I urge you to respect them and their efforts. They take their job every bit as seriously as we do.

5:00 P.M.

From 5:00 to 5:30, we again returned to the office to try to answer more phone calls. We also had another meeting with a lobbyist. This lobbyist came to speak against a pending bill that was supported by the senator. The exchange was honest, candid and

unquestionably valuable to both. Minor compromises were reached, but I doubt that either mind was changed. The senator held a 15-minute discussion with his staff about activities for the next day. Then, we went to dinner.

7:00 P.M.

Dinner was again spent with lobbyists who were trying to impart information to the senator about legislation that had not yet been proposed and may never be proposed. Again, this was an

educational session and not an attempt to influence a vote. From 7:00 to 9:00, we returned to the Senate for one last committee meeting on Financial Institutions and Insurance.

9:30 P.M.

We finally left the Capitol chambers at 9:30. This time, we retired to yet another "Senate office," the lounge at the Hyatt on Capitol Square. Discussions continued there with various state senators and representatives. Some of the information shared was good, some, unfortunately, not. In this environment, however, it was easy to talk to the representatives, and they to me. I was welcomed by everyone — senators, representatives, constituents, employees and lobbyists alike. I am beginning to understand, however, the need for our presence with the legislators at all hours.

I hope each member of the OSMA will be willing to participate in the legislative process if given an opportunity to do so. If you do plan on attending a session, let me offer you a hint for success: Wear a lapel pin. Two or three pins is even better. These should be small, shiny, gold, with red, white and blue colors. Best yet, a tiny American flag. If you

have no better lapel pin, the OMPAC/AMPAC pin will suffice. If you go without a lapel pin, you might as well go naked.

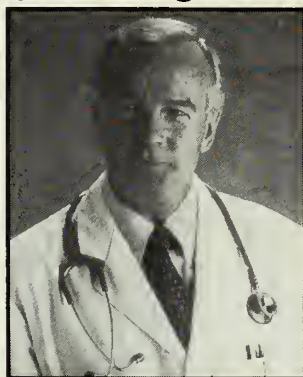
My general impression is this: Making laws may well be similar to making sausage. If you watch either being made, you will never enjoy it again. Still, my overall perception is extremely favorable. Members of the Ohio Senate work very hard on our behalf, and deserve our support.

Being an Ohio state senator is not a part-time job. The issues they address are complex and highly specialized, and each senator is expected to thoroughly understand the materials so that he or she can vote appropriately. This requires considerable time, analysis and good staff, as well as input from knowledgeable people such as ourselves. We can influence legislation, and we must. Our input is essential. As the saying goes, "in politics, you are either a participant or a victim." And who wants to be a victim? **OSMA**



Ronald L. Price, MD

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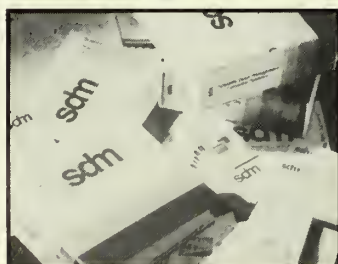
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Practice parameters: friend or foe?

"The \$64,000 question is, if you don't follow practice parameters and something goes wrong, will you be found negligent and therefore liable?"

The question was posed by Michael Ile, JD, of the AMA's Department of Health Law, this past spring at the Annual Meeting of the OSMA's Hospital Medical Staff Section. Yet the question is one that has been raised time and time again since the development of those standards or guidelines known as practice parameters.

Background

"Practice parameters are nothing more than strategies," says Robert McAfee, MD, vice chair of the AMA's Board of Trustees, who preceded Ile on the OSMA-HMSS program. "They should allow us to take a look at ourselves and the way we are practicing medicine."

Ideally, parameters should establish a more efficient way of producing the best medical outcome. For example, parameters may reduce the number of hip replacement hardware currently in use from eight to the two best. Yet parameters, say their advocates, are not necessarily about cost but about quality assurance. They are a way to expose you to other treatment modalities that have proven to be effective but which you may not have known about because you weren't trained to try that method or because, traditionally, you have never used that method.

"True peers will question why you need to do this procedure in this way, when there may be another procedure that is just as effective," says Dr. McAfee.

Evolution

That explains, in part, Dr.



Robert McAfee, MD

McAfee continues, how practice parameters evolved.

"First of all, many procedures can't be limited by a single guideline," he says. Patients and resources vary so greatly that often a broader standard becomes necessary.

Inappropriate care studies conducted over the last several years have also set the climate for practice parameters. "The 66% inappropriate care figures have been grasped by the media and third parties. That's a challenge that has to be met," Dr. McAfee says.

Finally, peer review organizations, struggling to find their own yardstick when it comes to measuring quality of care have made practice parameters a practical idea.

So, the AMA has proceeded to establish four practice parameters of its own through its new Agency for Health Care Policy and Research, and presently serves as a clearinghouse for other groups,

primarily specialty societies, which are setting up their own parameters.

"These parameters must have five attributes," says Dr. McAfee. They must be drawn up in conjunction with a physician organization; be established by reliable methodology; be as comprehensive and specific as possible; be based on current information; and be widely disseminated.

"The cost factor is eliminated from the parameter," Dr. McAfee continues. "If the best way is unaffordable, then society needs to make that choice — not the physician."

Concerns

Still, the AMA and physicians in general have concerns about these established guidelines, says C. Irving Meeker, MD. Dr. Meeker is quality assurance officer of the Maine Medical Center and on the executive board of the American College of Obstetricians and Gynecologists, which have been using practice parameters for some time.

"The objective of a parameter is optimal care and patient satisfaction while, at the same time, controlling both costs and medicolegal risks," he says. However, a good outcome too often depends on who is defining it — payor, patient, regulator or society — which, in turn, leads to schizophrenic definitions, "maybe part of the underlying problem," says Dr. Meeker.

Other comments expressed by opponents of practice parameters include:

- "This is cookbook medicine, it takes away the art."
- "Patients are different. Parameters reduce flexibility in treating them."
- "There is more than one or two right ways to proceed."

Legal

- “Parameters may become the ceiling rather than the floor. In other words, if that’s all I have to do, that’s all I’ll do.”

- “Some diagnoses are too complex for practice parameters.”

- “How can parameters hope to keep up with changing knowledge?”

Then, there are the legal concerns.

Parameters and liability

The answer to that \$64,000 question posed earlier is “no,” says Ile, but you probably *will* be asked whether or not you considered the parameter when making your treatment decision, as well as for any documentation you have that shows why you didn’t follow the parameter.

“And just because you followed a parameter doesn’t mean you’re out of the woods (in malpractice suits),” says Ile. He reminds physicians that ultimately they are responsible for the patient, no matter what parameters have been set up by medical societies, specialty societies or third parties.

“Parameters may not be the enemy you might think them to be,” adds Katrina English, JD, OSMA associate staff counsel. “They provide a definition of standard of care.”

Standard of care, of course, is one of the determining factors in malpractice suits. Once duty to a patient has been established, a physician is then judged on whether or not he or she has violated that duty, based on a national standard of care. That’s where parameters may enter the picture, says English. Courts may ask in the future if certain parameters are relevant and, if so, do they apply to this particular patient? Assuming they do, has the physician deviated from these

parameters?

“Practice parameters will be one piece of evidence to determine physician negligence,” says English. “They provide a definition of the standard of care, so they may offer a better starting point than anything that has existed in the past.”

William Todd, JD, of Porter, Wright, Morris and Arthur, OSMA’s outside legal counsel concurs.

“Practice parameters are a valuable defense tool. They will carry a great deal of weight in the courts.” He points out that, with courts now reducing the amount of time an expert witness needs to spend in the practice of medicine (from 3/4 to 1/2), practice parameters may provide a counterbalance. And, Dr. Meeker says, practice parameters might even lower liability premiums.

“The only way practice parameters will hurt you is if a practice parameter exists, a good one, and you’re deviating from it for no reason,” he says.

“Parameters won’t be the solution to the malpractice crisis,” English sums up, “but they certainly might help in some circumstances.” OSMA

National Practitioner Data Bank update

- **Expansion halted . . .** Plans, first proposed in March, to expand the NPDB by including additional information regarding medical malpractice actions have been successfully stopped by public comment, despite a short (30-day) comment period. The PIE

Mutual Insurance Company was one of several agencies that rallied physicians to respond to the proposed expansion. According to Fitzhugh Mullan, MD, director of HHS’s Division of Quality Assurance, Bureau of Health Professions, Health Resources and Services Administration, 66 public comments were received and, “while some respondents supported the concept or acknowledged the need for additional data, many commenters opposed going forward with the expansion.” The most frequent concerns expressed by letter writers included: substantial increases in reporting time and costs, exceeding statutory intent, adverse operational implications and liability, confidentiality and security issues. After reviewing the comments, the department decided in May not to proceed with its proposal to expand the research capacity of the data bank.

- **Policy on impaired physicians changes . . .** Physicians who voluntarily participate in an impaired physician program no longer need to be reported to the NPDB. After discussions with the AMA and others, the NPDB guidebook was changed to read: “entrance into a drug, alcohol or psychiatric rehabilitation program does not, in itself, constitute a reportable action.” A report is necessary only if there has been a suspension of a practitioner’s license as the result of action based upon professional competence or conduct.” Directors of rehabilitation programs had expressed concern that the threat of being reported to the data bank would discourage impaired physicians from voluntarily seeking help.

Additional data bank information is available from the

OSMA Department of Legal Services, 1500 Lake Shore Dr., Columbus, OH 43204-3824. OSMA

Fraud and abuse and the physician entrepreneur

It looks like a golden opportunity. You're asked to invest in a home health-care business and the price is right — only \$5,000. As a family practitioner with a sound referral base, you will earn 20% on your investment. Your colleague, John Smith, MD, an anesthesiologist, likes the investment, too, and is willing to pay the \$5,000. Because he isn't able to provide the business with referrals, however, he will earn only 10% on his investment. If you're about to sign on the dotted line, hold up. You may be in violation of the "fraud and abuse" law, otherwise known as the "federal anti-kickback statute."

Background

The statute evolved from a medical marketplace that became more commercial and more competitive in the 1980s. As Medicare began to pay hospitals flat fees for patient stays, outpatient clinics proliferated, and doctors looked to these facilities as a way to supplement a newly shrinking income. But, as Arnold Relman, MD, editor of *The New England Journal of Medicine*, and an outspoken crusader against physician entrepreneurship has noted: "You don't have to be an Einstein to see that the more patients you refer, the larger your profits will be."

In fact, studies conducted by both the government and private groups have found that more than 10% of the nation's doctors have invested in businesses to which they refer patients (the AMA puts that figure closer to 8.2%), and these studies allegedly reveal that doctors who share ownership of health-care businesses order more services than other physicians.

Those studies prompted Congress to sit up and take notice. As a result, the anti-kickback statute (as well as other laws, see sidebar on the Stark bill), were passed to discourage the physician entrepreneurial system. These fraud and abuse regulations are so broad, however, that only an attorney can understand and interpret all the nuances involved.

"That's why we urge physician-investors to consult a good business attorney before closing on any contract," says Scott Clapp, JD, associate staff counsel in OSMA's Department of Legal Services.

Sound legal advice may indeed be your best protection since, in addition to its broad scope, the fraud and abuse act also makes the *recipient* of the payment just as liable as the payor. In other words, if you receive more income than other investors because of your referrals, or you are cut special deals because you offer a solid referral base, you may be in legal hot water.

Safe harbors

Of course, not all the referrals you make will land you in trouble. Congress created a number of statutory exceptions that, again, need an attorney to interpret successfully, "but, basically, it comes down to a question of intent," says Clapp.

Don't forget, however, that

"intent" is the government's interpretation — not your own — and the government has been struggling since 1987 to determine exactly what kind of safe harbors it will allow. Originally, Congress mandated the Department of Health and Human Services to have final regulations on safe harbors published no later than August 1989. The Office of the Inspector General, which oversees the statute, published its *proposed* safe harbor regulations in January 1989, but as of this writing, final regulations have not been promulgated, so the courts are interpreting fraud and abuse on their own terms — setting forth such broad judicial interpretations that the health-care community is often left wondering exactly what is safe and what isn't. Financial arrangements that may have totally legitimate purposes may inadvertently be structured in such a way as to run afoul of this statute.

As Clapp has pointed out, physicians will save themselves money in the long run if they consult a good business attorney *before* they sign any investment contracts.

"It's like third-party contracts," says Clapp. "They look straightforward, and you may think you know what you're signing, but you may be missing something that could cost you both in terms of penalty fees and Medicare eligibility."

Even if the business seeking your investment tells you the contract has been structured by its own business attorney to avoid any fraud and abuse interpretation, Clapp advises you to have your own attorney check it out anyway.

Potential problem areas

The following is a list of

Legal

potential problem areas — ones where, as a physician-entrepreneur, you should enter cautiously, and preferably with an attorney at your side.

“Remember,” says Clapp, “if the deal sounds too good to be true, it probably is. Seek legal advice.”

Joint Ventures

In 1989, the OIG issued a “Special Fraud Alert” in which it identified three categories of “questionable features” of joint ventures. The first category dealt with the manner in which investors are selected and retained; the second with the business structure utilized by the joint venture; the third with financing and profit distribution methods. If you are thinking of entering a joint venture, have your attorney check these areas before you close the deal. Keep in mind, however, that the uncertainty of the scope of the anti-kickback statute, plus the growing sentiment in Congress to prohibit physician ownership, make joint ventures a speculative proposition. Proceed cautiously.

Percentage Lease Agreements

Lease arrangements in which you lease space and/or equipment to a business won't raise concerns if there is no referral of patients between parties. For example, let's say you are a cardiologist and you lease space in your building to a dentist. Chances are, you may mention to a patient who is in need of a dentist that there is one in your building, but you are not establishing any referral patterns by doing so. However, if you lease space to a family practitioner who may refer patients to you — there may be a legal problem depending on the structure of your lease. In other words, if there is a direct

First the labs . . . then imaging centers?

In 1989, a study by Richard Kusserow, inspector general of the Department of Health and Human Services, found that patients of doctors who own or invest in clinical laboratories received 45% more lab services than Medicare patients in general. This increased use, the study said, cost Medicare \$28 million in 1987.

A short time later, Rep. Pete Stark (D-California) introduced a bill that prohibited doctors from referring Medicare or Medicaid patients to clinical laboratories in which the doctors have a financial interest. Congress, already alarmed by the Kusserow study, lost no time in passing the measure.

The law becomes effective January 1, 1992. To comply with the new statute, physician investors must, in most cases, either sell their interest in the laboratories, or refer their Medicare and Medicaid patients to other labs.

But that's only part of the picture. Rep. Stark is now contemplating new legislation that would halt what he refers to as the “terrible overutilization and waste that occurs when doctors refer patients to facilities where they have an ownership interest.” As a result, Congress, as well as several states, is contemplating placing similar restrictions on referrals to other

doctor-owned businesses, such as diagnostic imaging centers and medical equipment suppliers. In Ohio, Rep. Wayne Jones has presented a bill, H.B. 478 which, among other things, would restrict physician referrals to entities in which they have a financial interest. (See Legislation Section.)

The American Medical Association has gone on record in defense of physician investments. The AMA calls them proper, and even beneficial since they often bring new technology to the marketplace.

However, Arnold Relman, MD, editor of *The New England Journal of Medicine*, has openly attacked the physician entrepreneurial system. “When you earn money by referring to a facility where you are an investor, you're just using your patient as an economic commodity,” he has said. Nevertheless, he seems to understand the underlying basis of the system. “The whole climate in medicine is becoming more commercial and competitive,” he says. “It's putting doctors in situations that force them to behave like entrepreneurs to survive.”

There is little doubt that the matter of physician entrepreneurs will be a hot topic for some time to come. *OHIO Medicine* will keep you posted of any new developments. **OSMA.**

referral relationship or the ability to influence referrals, consult your attorney. Parameters have been set up by the proposed safe harbor regulations, and your attorney should be able to tell you whether or not your compiles with those

criteria.

Discounts, free goods and services

Although the fraud and abuse statute contains an exception for discounts (provided they are reflected in costs or charges made

Legal

by the Medicare program), there are still several caveats of which you should be aware. Generally, physicians should avoid arrangements where the level of the discount on private laboratory tests is conditioned upon the volume of Medicare referrals to that lab, and avoid those free goods that are provided by suppliers as the result of physician referrals, but which are totally unrelated to patient goods (i.e. the pacemaker manufacturer who provides free trips to the cardiac surgeon based on utilization of pacemakers).

Physician recruitment and retention incentives

Although the OIG may be considering a safe harbor on this issue, physicians should be cautious in entering into arrangements with hospitals that offer incentives either to join a medical staff or to remain with one. Avoid any programs, however, that require either a mandatory number of admissions or exclusive admitting privileges.

Paperwork completion fees

The solicitation or acceptance of paperwork completion payments (offered to physicians by durable medical equipment suppliers for completing certificates of medical necessity for their patients) carries with it a significant risk of fraud and abuse. Avoid these arrangements entirely.

Financial arrangements between hospitals and hospital-based physicians

In order to reduce potential legal liability in this area, contracts between hospitals and hospital-based physicians should be: based upon fair market value of services rendered; be unrelated to physician income or billings; and be limited

Sophisticated scams

Suddenly, the nation's soaring health-care costs have led to increased attention to health-insurance fraud. Both insurance companies and inspectors with the Department of Health and Human Services are now pursuing and prosecuting health-care fraud cases aggressively, and with good results. Insurers, for example, are finding that for every dollar they spend suppressing fraud, they recover \$4, so they're beefing up their fraud units, and HHS inspectors, who used to win 15-20 health-fraud convictions a year, are now winning 150-160.

Most scams are not perpetrated by doctors (the HHS says only 20 of its 160 fraud convictions won last year were against physicians). However, physicians are likely targets of the con artist's scheme, and they should be aware that these schemes have become more complicated and more difficult to detect. Here are a few scams you may want to keep your eyes open for — both for your sake, and that of your patients:

- The TENS scam — Beware the person who wanders into your office and offers to pay you and your office assistants for every transcutaneous electric nerve stimulator unit (TENS) you prescribe. One con artist who did this would pick up the claims forms, which billed insurers for the TENS rental, and change the address so checks were diverted to a mail drop. He then forged

the patient's name, and deposited the check into his own account. He was eventually caught, but while he awaits sentencing, he is reportedly repeating the scam — this time with nebulizers.

- The medical equipment rip-off — Tell your Medicare patients specifically what kind of medical equipment they need to manage their health-care problems, and to consult you before purchasing any additional equipment. Telemarketers are now cross-matching mailing lists to identify Medicare recipients and their health problems — then selling them a bill of goods at wildly inflated prices. Among the rip-offs: a foam pad to prevent bedsores, costing \$28.57 and priced at \$1,132.

- Prescription mills — The use of phony prescriptions to obtain narcotics for illegal resale. It's the oldest and most prevalent scam in the book. Keep your prescription pads with you or under lock and key.

- Recovery scams — The collection agency that calls you and offers to pursue your delinquent accounts may be pursuing their own gains as well. One con artist called a doctor and offered to go through his oldest accounts receivable to see what bad debt he could recover for the doctor. Then, the scammer proceeded to Xerox the claim forms, change the addresses and resubmit the old claim forms to insurance companies.

The moral? Let the physician — and his or her patients — beware. **OSMA.**

to goods and services needed by the hospital-based physicians.

Any questions you may have regarding the fraud and abuse statute, or proposed safe harbor

regulations should be directed to OSMA's Department of Legal Services, 1500 Lake Shore Drive, Columbus, OH 43204-3824. **OSMA.**

Science and Education

One way to serve the post-menopausal patient

Margery L.S. Gass, MD
Robert W. Rebar, MD
James H. Liu, MD
University of Cincinnati College of
Medicine
Department of Obstetrics and Gynecology

We are at a time in history when women are interested in more active participation in their health care. Medical articles in the lay press abound, and patients are sometimes misled by articles that are basically accurate, but, because of journalistic constraints, the articles may not present the entire picture. With these considerations in mind, a two-hour public seminar on the topic of menopause and osteoporosis was offered on a recent Saturday morning by a local hospital. The scheduled speakers included three physicians and a physical therapist who addressed the following subjects: the normal aging process, osteoporosis, hormone replacement therapy, and exercise for posture and fitness.

In general, the women attending the menopause and osteoporosis symposium were well-educated, middle-class Caucasians who were seeking more information than their regular physician had provided. This perceived lack of information might be attributed to: patients who often do not absorb all of the facts presented to them at one visit, and/or those physicians who do not present enough information, either from lack of facts, lack of interest or lack of time. These women appear to represent a new group of patients who seek to be better informed with respect to issues affecting their health and who

show an interest in participating in the decisions that will influence their quality of life in the future. This symposium demonstrates the need for providing health care in new ways.

In response to the perceived need for more medical information and services in the area of menopause and osteoporosis, a multidisciplinary center was created at the University Hospital in Cincinnati. The center provides medical education and information for the public, coordinates treatment and services from several specialties for the patient and monitors research investigations in the area of menopause and osteoporosis.

At the center, patients are interviewed and examined. Books, brochures and videotapes are available for patient self education. The patient is also given a bibliography of books addressing related topics. Mammography and physical therapy are available when indicated. It is anticipated that bone densitometry will be on site in the near future. The central

availability of these services makes it possible for the patient to accomplish several aspects of their health care more efficiently.

With regard to physician services, a number of specialties are represented: gynecologists, gynecologic endocrinologists, internists, geriatricians and physical medicine specialists. By having this group of physicians meet regularly, the care of complicated patients is facilitated while the patient benefits from the collaboration of several specialists.

Additional support services would include a physical therapist, a nutritionist, a psychologist and research nurses. A comprehensive program such as this involves a large number of people committed to the concept of a center. The willingness on the part of these people to contribute time and expertise is crucial to the success of the program. Based on this symposium, and others similar to it, we believe that we are providing care in a setting desired by a segment of postmenopausal women. **OSMA**



Science and Education

Arthropod-borne disease summary for Ohio physicians

The Ohio Department of Health

Purpose: The purpose of this summary is to inform physicians and allied professionals about tick and mosquito-borne diseases. We anticipate producing an update several times annually and we solicit your input to best serve your needs.

Lyme Disease

National trends¹: Reported cases of Lyme disease (LD) from 1986 through '89 doubled or nearly doubled each year. The provisional 1990 data appears to end this trend in that 7,995 cases have been reported and this is 557 fewer than the final total for 1989 (8,552). In prior years more than 500 late reports have been filled after the provisional report. This may reflect a plateau in case detection, decreased reporting by physicians, or the use of more stringent criteria in defining cases. Lyme disease became a nationally notifiable disease and a new national case definition was adopted beginning January 1, 1991 (see below).

State trends¹: Ohio had 99 cases in 1989, 113 provisional cases were reported in 1990, and 44 have been reported thus far in 1991. Many of these Ohio cases had potential tick exposure outside the state. By comparison, neighboring states reported the following in 1989 and 1990 (parenthetic value is LD cases in '89): Indiana (8) 15; Kentucky (21) 18; West Virginia (15) 11; Pennsylvania (681) 553. States reporting the highest incidence of Lyme disease in 1990 (provisional cases 100,000⁻¹): Connecticut, 21.55; New York, 18.15; New



Lyme update

Willy Burgdorfer, MD, of the National Institutes of Health Rocky Mountain Laboratory, Hamilton, Montana, visited the Ohio State University Department of Entomology recently to give an overview of Lyme Disease, "Ten Years after Discovering the Etiologic Agent Borrelia burgdorferi." According to Dr. Burgdorfer, Lyme disease was once thought to be limited to Europe but has now spread to China, Japan, the United States and Asia. It affects thousands of men, women and children every year. He emphasized that the major problem seems to be the lack of standardized tests, which can lead to false results. He feels that the next 10 years will deal more with the treatment of the disease.

Jersey, 13.75; Rhode Island, 10.12; Delaware, 7.92; Wisconsin, 6.88; Maryland, 5.09; Pennsylvania, 4.59; Missouri, 3.94; Georgia, 2.44.

Ohio update²: The Ohio Public

Health Council added LD to the list of Class A Reportable Diseases in June, 1990. Thus, all suspected LD, as well as Rocky Mt. spotted fever (RMSf) and viral encephalitis must be reported to the local health department where the patient resided. Despite intensive efforts to detect deer tick (*Ixodes darnmint*) populations in Ohio, only three deer ticks have been collected in Ohio since 1989, two from deer (October, 1990, Williams & Clermont Co.) and one was found crawling on a person (June, 1989, Butler Co.). Thus, the greatest risk of infection to Ohio's citizens remains out-of-state travel to endemic areas. Physicians should include questions about travel when discussing the patient's symptoms, and a follow-up question about exposure to tick habitats or tick-bite history would be appropriate. In patients with chronic symptoms a detailed out-of-state travel history going back several years may be instructive.

Lyme disease hot-line³: Individuals with touch-tone phones can access the Voice Information Service at CDC in Atlanta by dialing 404-332-4555. Pressing the appropriate numbers when requested to do so will activate general and topic-specific information on Lyme disease, as well as other infectious disease problems.

Malaria therapy for Lyme disease is not recommended³: MMWR³ 1990;39:873-75.

National Lyme disease in pregnancy registry is encouraged¹: MMWR 1985;34:376-384. Contact Dr. Roy Campbell (303-221-6474) for information or registration.

Lyme Disease National Surveillance Case Definition

"Lyme disease is a systemic, tick-borne disease with protean

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manifestations, including dermatologic rheumatologic, neurologic and cardiac abnormalities. The best clinical marker is the initial skin lesion, erythema migrans (EM), that occurs in 60%-80% of patients."

A case of LD for surveillance purposes is defined as follows:

- a person with erythema migrans; or
- a person with at least one late manifestation and laboratory confirmation of infection.

Please note that laboratory confirmation cannot be made with certainty due to inadequate sensitivity and specificity of the tests, as determined in a recent study by the CDC. At present, diagnosis must rely on compatible symptoms. A travel history to one of the more endemic states, with tick potential exposure, may be helpful in arriving at a diagnosis.

General clinical epidemiologic definitions of Lyme Disease

1. Erythema migrans (EM)

For purposes of surveillance, EM is a skin lesion that typically begins as a red macule or papule and expands over a period of days or weeks to form a large round lesion, often with partial central clearing. A solitary lesion must reach at least 5 cm in size. Secondary lesions may also occur. Annular erythematous lesions occurring within several hours of a tick bite represent hypersensitivity reactions and do not qualify as EM. In most patients, the expanding EM lesion is accompanied by other acute symptoms, particularly fatigue, fever, headache, mild stiff neck, arthralgia, or myalgias. These symptoms are typically intermittent. The diagnosis of EM must be made by a physician. Laboratory

One man's battle with Lyme disease

A dream vacation to his cousin's lavish summer home off the coast of Camden, Maine, turned into a nightmare for Bill Garrard.

The Worthington (a suburb of Columbus) insurance agent's life has changed dramatically in the past 21 months since he was bitten by a tick.

"I remember coming back from a long hike in the woods. I saw a little guy that looked like a freckle running through the hair of my arm, I casually flicked it off, and didn't think anymore about it," says Garrard.

Once a very active, healthy man who could bench-press a few hundred pounds, Garrard now greets each day with tremendous fatigue. It's impossible for him to drive a car or concentrate on any one subject for too long a time because of his neurological problems attributed to the Lyme disease. The four or five hours a day when he does feel good he takes advantage of it whether it's at 8 a.m. or midnight. Fortunately, Garrard is self-employed, so his work schedule is flexible. "It's like being up for two days straight, having the flu and having mononucleosis all at the same time," explains Garrard. "How could such a tiny, little thing take down someone my size?" asks the burly Garrard.

It was shortly after returning from Maine back in September of 1989 that Garrard first noticed a bull's eye rash — one of the characteristic signs of Lyme disease — on his leg. The rash lasted about three weeks. On the advice of his wife, Carole, a nurse at Children's Hospital in Columbus, Garrard went to see

his family physician, Ted Herwig, MD, who thought it looked like Lyme disease. Dr. Herwig prescribed doxycycline. Garrard took the oral antibiotic for 78 days. After the rash disappeared Garrard continued to have radiating pain up his arms and legs. He was tired all the time, showed flu-like symptoms and memory and concentration difficulties. Garrard was sent to a rheumatologist, then to an infectious disease specialist. Specialist after specialist gave him every test possible, including tests for chronic fatigue syndrome, mononucleosis and arthritis.

In November of 1990 Garrard paid a visit to Joe Joseph, MD, an internal medicine specialist in Hermitage, Pa., north of Pittsburgh, whom a friend had suggested he see. Garrard has since become a regular patient of Dr. Joseph's. Each month the Garrards pile into the car and begin their trek to Pennsylvania. Dr. Joseph has become somewhat of a guru on Lyme disease not necessarily out of choice but because so many patients in the area (it's estimated he treats about 800 Lyme disease patients) started coming to him for treatment.

Dr. Joseph put Garrard on a six week supply of IV roceprhine. Garrard admits he's better but not 100%. Garrard's only hope is that as more information about the treatment of Lyme disease is uncovered something will be found for him. In the meantime, Garrard and friends and neighbors clip and save every article on Lyme disease that they find, searching for answers. OSMA

Science and Education

confirmation is recommended with no known exposure (but see note above).

2. **Late manifestations** include any of the following when an alternate explanation is not found.

a. Musculoskeletal system

Recurrent, brief attacks (weeks or months) of objective joint swelling in one or a few joints sometimes followed by chronic arthritis in one of a few joints. Manifestations not considered as criteria for diagnosis include chronic progressive arthritis not preceded by brief attacks and chronic symmetrical polyarthritis. Additionally, arthralgia, myalgia, or fibromyalgia syndromes alone are not accepted as criteria for musculoskeletal involvement.

b. Nervous system

Lymphocytic meningitis, cranial neuritis, particularly facial palsy (may be bilateral), radioculoneuropathy or rarely encephalomyelitis alone or in combination. Encephalomyelitis must be confirmed by showing antibody production against *Borrelia burgdorferi* in the cerebrospinal fluid (CSF), demonstrated by a higher titer of antibody in CSF than in serum (but see note above). Headache, fatigue, paresthesias, or mild stiff neck alone are not accepted as criteria for neurologic involvement.

c. Cardiovascular system

Acute onset, high grade (2nd or 3rd degree) atrioventricular conduction defects that resolve in days to weeks and are sometimes associated with myocarditis. Palpitations, bradycardia, bundle branch block, or myocarditis alone are not accepted as criteria for cardiovascular involvement.

3. **Exposure** is defined as having been in wooded, brushy, or

grassy areas (potential tick habitats) in an endemic county no more than 30 days prior to the onset of EM. A history of tick bite is not required.

4. **Endemic counties** are defined as those in which at least two definite cases have been previously acquired or a county in which a tick vector has been shown to be infected with *Borrelia burgdorferi*. (Note: as of June 1, 1991, no Ohio county is considered endemic).
5. **Laboratory confirmation** of infection with *B. burgdorferi* is established when a laboratory isolates the spirochete from tissue or body fluid, detects diagnostic levels of IgM or IgG antibodies to the spirochete in serum or CSF, or detects a significant change in antibody levels in paired acute and convalescent serum samples. States may determine the criteria for laboratory confirmation and diagnostic levels of antibody. Syphilis and other known causes of biologic false positive serologic test results should be excluded as appropriate, when laboratory confirmation has been based on serologic testing alone."

Save the Tick for Identification:

Did you know that no tick specimen has ever been identified in association with a Lyme Disease case in Ohio? If a patient shows you a tick that bit them, it can be identified at the Ohio Department of Health Vectorborne Disease Unit laboratory. Live ticks that are vectors of RMSf and that were removed from the patient can be tested for spotted-fever group rickettsia. Live ticks can be kept alive by placing them in a vial with a bit of paper toweling with one drop of water. Dead ticks should be preserved in 70% alcohol. Send ticks for ID

and testing to the Vector-Borne Disease Unit, Tick Testing, P.O. Box 2568, Columbus, OH 43216-2568.

Rocky Mountain Spotted Fever (RMSf, Tick typhus)

Rocky Mt. spotted fever is endemic in Ohio and its vector, the American dog tick (*Dermacentor variabilis*) is abundant and widespread. This tick can be found from April through August, and the population peaks during May and June. On a national basis, nearly half of the cases occur in the South Atlantic Region, and typically, the Carolinas and Oklahoma have the highest case rates. Thus, the name RMSf continues to be a misnomer.

RMSf in Ohio: From 1964-90, there were 491 cases reported from Ohio, for an average of 18 cases per year. Seventeen (3.5%) of these were fatal. During 1990, there were 25 cases reported, none were fatal. The top 10 counties in number of RMSf cases reported from 1964-90 were: Clermont (117); Lucas (107); Franklin (53); Brown (21); Washington (17); Highland (14); Athens (11); Delaware (10); Clinton (10); and Warren (10).

Diagnosis and Treatment of RMSf:

Classic symptoms include fever, headache, myalgia and rash, with approximately half of the rashes beginning on the palms and/or soles. Patients with these symptoms should usually be treated with tetracycline or chloramphenicol before results of serologic testing are available because diagnostic titers are not present in the majority of patients before the second week of illness (*Am. J. Trop. Med. Hyg.* 1986;35:840-4). Treatment should be considered for symptomatic patients who have

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been in an RMSf endemic area even if they do not have a rash and were not exposed to ticks. The ODH can perform serologic testing for RMSf.

- Numerous videotapes, slide sets and informative brochures are available from the Vector-Borne Disease Unit and will be listed in the next issue of ADSPO.
- The next issue of Arthropod-Borne Disease Summary for Physicians in Ohio (ADSPO) will focus on Lyme Disease Diagnosis & Treatment, proper methods for tick removal, an update on case incidence, and mosquito-borne encephalitis in Ohio.

¹Lyme Disease Surveillance Summary
Bacterial Zoonoses Branch
Division of Vector-Borne Infectious
Disease
Center for Infectious Diseases
Center for Disease Control
P.O. Box 2087
Fort Collins, CO 80522

²Ohio Vector News
Ohio Department of Health
Vector-Borne Disease Unit
P.O. Box 2568
Columbus, OH 43216-2568

³*Morbidity and Mortality Weekly
Report (MMWR)*

Steroids may halt progression of MS

Researchers at Cleveland's Mellen Center have launched a study that will concentrate on the use of a steroid to curb progression in multiple sclerosis patients.

Steroid use on MS patients is not new, however, says neurologist Donald E. Goodkin, MD, who is leading the study. In the past, he says, steroids were used on patients

who were having an attack. These studies showed that the steroids decreased attacks, and the duration of benefits lasted from six weeks to six months.

The Mellen Center study will use the steroid methylprednisolone in an attempt to prevent attacks, and during the course of the study, to attempt to prevent increasing disabilities.

Dr. Goodkin calls the steroid more "user-friendly" than current immunosuppressive drugs, which increase the risk of developing cancer — a side effect that often leads many patients to refuse additional treatment, even if regression begins a year or two after therapy.

The five-year study involves two years of steroid therapy, followed by three years of monitoring. **OSMA**

Teens will listen to this message about AIDS

"Be careful. (Teens) hear it all the time. But this is no joke. It's out there."

The speaker is a teenage mother who is HIV positive, and who has passed the AIDS virus on to her newborn daughter. She is addressing herself to her peers on a new videotape, produced by Children's Hospital Medical Center in Cincinnati, through a grant from the Ohio Department of Health. "It Can Happen to You: Adolescents and AIDS" is a 16-minute videotape, intended to give high-risk teens an idea of what it's like to deal with AIDS by presenting area teenagers who are either HIV positive themselves, or who are caring for family members who are. According to the ODH, at least 40 Ohioans with AIDS are under the age of 13; and 16 are

between the ages of 13-19.

The video discusses the importance of safe sex, the use of condoms, the hazards of intravenous drug use, and the spread of AIDS among teens and homosexuals. It is meant to be a supplemental tool for more comprehensive AIDS education.

Ellen Marino, coordinator of the Adolescent Center for Education at CHMC and the video's producer says: "The genuineness of their message and their way of putting things is better than anything I could have ever written in a script."

The video can be borrowed free from the ODH through the Health Promotion Film Library, 246 N. High St., Columbus, OH 43226-0558. Or call (614) 644-7852. It's also available from the AIDS Activities Unit, ODH, 35 E. Chestnut St., Columbus, Ohio 43215, (614) 644-1838.

Cleveland Clinic researchers successfully map arteries

Within a year or two, cardiologists may be able to first map then remove the plaque in arteries, thanks to researchers at the Cleveland Clinic who this summer used a new laser system to make the world's first successful map of plaque in arteries.

The team placed a catheter inside the coronary artery of two consenting patients during open-heart surgery. The catheter beamed low-intensity light along the inside of each artery. Healthy tissue glowed green, plaque red.

The difference between this project and other failed attempts to make arterial laser maps may

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have to do with the difference in low-intensity lasers and precise aim, says John R. Kramer, MD, who headed the Cleveland Clinic project.

Dr. Kramer predicts the combined system of diagnosis and removal could be in clinical use in a year or two. **OSMA**

Will Koop's "smoke-free society" have to wait for Ohio to catch up?

How far has Ohio come toward former Surgeon General Everett Koop's call for a smoke-free America? The answer depends, to a certain extent, on where you live.

Columbus still remains a fairly comfortable place for those who insist on lighting up an assortment of tobacco products, but there *are* other areas around the state that have put out the fire through local ordinances and regulations. Among these are:

- Toledo — In addition to recent ordinance regulating tanning parlors, the Toledo city council has also prohibited smoking in all enclosed public places and workplaces, except in designated areas. Vending machines have also been prohibited, "where minors have access."
- Cleveland (and seven suburbs) — Here, too, smokers are prohibited from smoking anywhere other than designated areas in enclosed public buildings, but workplaces are also required to have a smoking policy. To further discourage smokers, the city increased the county excise tax

on cigarettes.

- Akron — Smokers in government buildings, restaurants and workplaces must seek out designated smoking areas or extinguish their cigarettes, cigars, etc.
- Cincinnati — This city has taken a moderate stand, prohibiting smoking except in designated areas in some enclosed public places and workplaces. However, shopping malls, factories and warehouses are excluded.

Other Ohio cities with smoking restrictions include: Medina, Akron, Warren, North Canton, Barberton, Xenia and Athens.

However, Richard Lanese, MD, a professor of preventive medicine at the Ohio State University, recently noted in a *Columbus Dispatch* article that the no-smoking movement may have peaked and might now require legislation to prod back into action. "Almost three-fourths of the policies . . . have been written in the last three years. It's going to move much more slowly now," he said.



Summary of Ohio laws on smoking

- Prohibited for students in school or at school-related activities.
- Prohibited on public transportation vehicles.
- Posted non-smoking areas are required in enclosed places of public assembly — except restaurants, bowling alleys and taverns.
- The sale of cigarettes is restricted to persons age 18 and older.

Ohio already has several state laws on the books regarding smoking (see sidebar), but overall it has been relatively inactive lately with regard to enacting anti-smoking legislation. Its last significant new law regarding the restriction of tobacco products was passed in 1988.

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More interest in smoking restriction may come about next summer when the American Lung Association, American Cancer Society and the American Heart Association sponsor a statewide conference intended to assess Ohio's progress against smoking and to develop strategies for legislation.

Until then, smokers, at least those in Columbus, can continue to fan the flames. **OSMA**

Residency programs fail to recognize domestic violence

Despite startling statistics that surround the issue of domestic violence, residency programs offer limited or no training on the issue of domestic violence, says a report published in the *Morbidity and Mortality Weekly* report, compiled by the Centers for Disease Control.

The study, conducted by Marybeth Hendricks-Matthews, director of behavioral sciences at Akron's Barberton Citizens' Family Practice Program, found that nationally, one-quarter of the residency programs provided no training at all on the problem of domestic violence.

One residency director wrote on the survey form, "We don't have it on the curriculum, we haven't had a battering victim in years." That comment, says Hendricks-Matthews, is a symptom of the problem. "If you don't ask, you

don't see," she notes.

According to a report published last year by the AMA, the problem is extensive. The AMA study found that 22%-35% of women who show up in hospital emergency rooms are victims of domestic violence. Many, however, are embarrassed to admit they were beaten by a husband or boyfriend, says Hendricks-Matthews, so it is crucial that physicians are trained to recognize signs of abuse. **OSMA**

Respiratory research to get boost from new merger

The University of Cincinnati Medical Center is joining forces with local industry giant, the Procter and Gamble Company, to develop a new biomedical research department at UC.



Together, the two hope to make major advances in understanding how respiratory and pulmonary diseases begin, and develop new drugs to combat them. Scientists from both P & G and UC will be working on the research, under the guidance of a clinical investigator.

"As long as people cough, wheeze and sneeze, we'll be looking for a way to stop it," says Donald Harrison, MD, senior vice president and provost for health education at UC.

Cincinnati researchers have already made inroads into understanding respiratory disease in children. The city's Children's Hospital Medical Center has been studying ways of combating lung disease in premature infants, for example. The new research department is expected to continue this theme by providing a better understanding of respiratory disease in adults. **OSMA**

One Of A Kind



Zantac[®]
*ranitidine HCl/Glaxo 150 mg and
300 mg tablets*

Please see Brief Summary of Prescribing Information on adjacent page.

Glaxo/ROCHE

Zantac® 150 Tablets
(ranitidine hydrochloride)

Zantac® 300 Tablets
(ranitidine hydrochloride)

Zantac® Syrup
(ranitidine hydrochloride)

CONDENSED BRIEF SUMMARY

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIONS AND USAGE. Zantac® is indicated in:

1. Short-term treatment of active duodenal ulcer. Most patients heal within four weeks.

2. Maintenance therapy for duodenal ulcer patients at reduced dosage after healing of acute ulcers.

3. The treatment of pathological hypersecretory conditions (eg, Zollinger-Ellison syndrome and systemic mastocytosis).

4. Short-term treatment of active, benign gastric ulcer. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.

5. Treatment of gastroesophageal reflux disease (GERD).

Symptomatic relief commonly occurs within one or two weeks after starting therapy and is maintained throughout a six-week course of therapy.

In active duodenal ulcer, active, benign gastric ulcer, hypersecretory states, and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy. 2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although recommended doses of Zantac do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Pregnancy: Teratogenic Effects: Pregnancy Category B: Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: Headache, sometimes severe, seems to be related to Zantac administration. Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and, rarely, pancreatitis have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, atrioventricular block, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid intravenously for seven days, and in 4 of 24 subjects receiving 50 mg qid intravenously for five days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia have been reported.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling.)

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg or 10 ml (2 teaspoonsful equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30° C (59° and 86° F) in a dry place.

Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 ml in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25° C (39° and 77° F). Dispense in light, light-resistant containers as defined in the USP/NF.

September 1990

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Reimbursement

Ohio physicians speak out on Medicare

William J. Geiger, MD
Associate Director
W.W. Knight Family Practice Center

Ronald A. Krol
Assistant Director
W.W. Knight Family Practice Center

Medicare reimbursement policies have recently become an emotional issue, as well as the frequent topic of editorials and letters where such terms as "harassment" and "MAAC attack" are used with abandon. Several physicians blame low Medicare reimbursement rates for reducing the amount of office time they can spend with each Medicare patient.

Few studies, however, have established if these attitudes and behaviors are widespread among physicians, particularly primary care physicians, so last year we surveyed, with the Ohio Academy of Family Physicians and the Ohio Society of Internal Medicine 1,758 of their members to make the determination. Over 800 surveys were returned, for a response rate of 48%. Here is what those surveyed said:

- 48% agreed that geriatric care was enjoyable.
- 52% reported that Medicare reimbursement policies had decreased their enjoyment of care for the elderly.
- 62% felt that recent changes in Medicare reimbursement policies had created anxiety and confusion among their elderly patients.
- 65% felt the Medicare paperwork had been a more significant factor in the increased workloads of their clerical staff than other reimbursement plans.
- 63% felt that Medicare policies had resulted in a decrease in their practice incomes.

Physicians Ranking Specific Medicare Policies as "Objectionable" or "Very Objectionable"

	Percentage	Number
Restrictions on concurrent care billing	93%	592
"Medical necessity" letters	90%	578
Civil monetary penalties	84%	539
Incentives to participate	82%	529
Maximum allowable actual charge (MAAC)	82%	524
Peer review organizations	71%	455

- 39% felt that levels of Medicare reimbursement were too low to cover their overhead per patient.

A large majority of respondents also indicated problems with specific Medicare policies (see sidebar "Physicians Rank Medicare Policies").

In response to questions about how physicians were changing their practices in response to Medicare reimbursement policies:

- 36% stated they were making no changes.
- 15% were accepting no new Medicare patients.
- 27% were taking less time with each Medicare patient.
- 38% were limiting their nursing home practice.

Overall, 50% reported they were taking at least one of the above actions to change their Medicare practice.

Survey results also showed that:

- Family physicians were more likely to restrict their Medicare practices than general internists.
- Non-participating physicians were more likely to limit their practice than "participating" physicians.
- Respondents who *enjoyed* geriatrics were less likely to limit their practice than those whose enjoyment of geriatrics were

markedly *decreased* due to Medicare policies.

- Respondents who perceived that Medicare reimbursement policies had increased clerical workload, decreased income or not covered their overhead per patient were more likely to limit their practices.

- Physicians with a smaller Medicare practice were also more likely to limit their elderly care.

Although there are some limitations to the survey (the response rate was disappointing and the study only surveyed Ohio primary care physicians so it is not applicable nationwide), important conclusions can be drawn:

1.) Ohio primary care physicians feel strongly that Medicare policies are negatively affecting both elderly patients and their practices. They see patients confused by a system that no longer provides access to medical services at a reasonable cost. They also see their staff work loads increasing and their incomes decreasing as a result of Medicare's new policies.

2.) Half of primary care physicians are taking some steps to limit their Medicare practice. Of physicians who are limiting their Medicare practice, the most frequent method of doing so is to reduce nursing home care, perhaps

Reimbursement

with the belief that these patients can be easily passed to nursing home medical directors.

3.) Family physicians more frequently limit their Medicare practices than general internists. There may be a number of reasons for this finding, including a broader patient base for family physicians. This reason seems to be supported by the finding that physicians with a smaller proportion of Medicare patients are more likely to limit their practice.

4.) Medicare "participating physicians" are less likely to restrict their practices, which may reflect a greater tolerance of the entire Medicare system. Likewise, physicians who most enjoy caring for the elderly are less likely to limit their geriatric practices, probably tolerating the system because of their dedication to these patients.

5.) Physicians who think their practices are negatively affected by changes in Medicare reimbursement policies seem to be trying to protect their practices by limiting the number of Medicare patients they see. After all, if the workload is *increasing* and income is *decreasing*, business sense dictates a move to more profitable markets. The survey's findings indicate that physicians are *not* an exception to this rule. **OSMA**

New ODH committee to study access, costs of cardiac catheterizations

The Ohio Department of Health has recently established an Ad Hoc Advisory Committee on Cardiac Catheterization to improve the accessibility, cost and quality of health services throughout the state, specifically in the area of cardiac catheterization.

The committee is composed of seven Ohio physicians, appointed by Gov. George Voinovich.

Raj Tripathi, MD, a cardiologist on the medical staff at Guernsey

Memorial Hospital, Cambridge, is one of those appointed to the committee. In news reports that followed announcement of his appointment, Dr. Tripathy explains the reasons for the special ad hoc committee:

"Many Ohioans have expressed concern regarding the accessibility and cost of cardiac catheterizations. In an effort to ease those concerns, our committee will investigate and discuss many items relating to health care in general and cardiac catheterizations in particular." **OSMA**



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Obituaries

EDWARD ARNOLD, MD, Canton; Ohio State University College of Medicine, 1931; age 85; died May 20, 1991; member OSMA and AMA.

WILLIAM R. BEERY, MD, Canal Winchester; Ohio State University College of Medicine, 1942; age 73; died June 20, 1991; member OSMA.

JOSEPH M. DENARDI, MD, Lorain; Case Western Reserve University School of Medicine, 1930; age 86; died June 21, 1991; member OSMA and AMA.

RICHARD G. DEUCHER, MD, Berea; Ohio State University College of Medicine, 1940; age 77; died June 20, 1991; member OSMA and AMA.

VAUGHN L. HARTMAN, MD, Boynton Be., FL; Northwestern University Medical School, Chicago, IL, 1925; age 89; died June 14, 1991; member OSMA and AMA.

JOHN W. HAUSER, MD, Boyne City, MI; University of Cincinnati College of Medicine, 1938; age 78; died June 25, 1991; member OSMA and AMA.

NORBERT L. KOSATER, MD, Green Valley, AZ; University of Cincinnati College of Medicine, 1952; age 66; died June 18, 1991; member OSMA.

DAVID O. MCKEE, MD, Canton; Tufts University School of Medicine, Boston, MA; age 82; died June 25, 1991; member OSMA and AMA.

JOHN A. MOSS, MD, Sarasota, FL; Ohio State University College of Medicine, 1939; age 78; died

March 13, 1991; member OSMA and AMA.

RICHARD R. NEITZ, MD, Tallmadge; Case Western Reserve University School of Medicine, 1950; age 68; died June 10, 1991; member OSMA.

IRVINE H. PAGE, MD, Hyannisport, MA; Cornell University Medical College, New York, NY, 1926; age 90; died June 10, 1991; member OSMA and AMA.

WARNER A. PECK JR., MD, Cincinnati; University of Cincinnati College of Medicine, 1946; age 70; died June 5, 1991; member OSMA.

EUGENE W. PETERS, MD, Cleveland; Ohio State University College of Medicine, 1931; age 87; died June 16, 1991; member OSMA and AMA.

ELMER A. SCHLUETER, MD, Cincinnati; University of Cincinnati College of Medicine, 1924; age 90; died May 14, 1991; member OSMA and AMA.

ROLAND F. SHIRLEY, MD, Cincinnati; University of Cincinnati College of Medicine, 1946; age 68; died June 30, 1991; member OSMA and AMA.

EARL E. SMITH, MD, Cleveland; Ohio State University College of Medicine, 1934; age 80; died June 11, 1991; member OSMA and AMA.

WALTER M. STOUT, MD, Westerville; Ohio State University College of Medicine, 1940; age 78; died June 10, 1991; member OSMA and AMA.

BENJAMIN F. WILLS, MD, Columbus; Ohio State University College of Medicine, 1934; age 83; died June 29, 1991; member OSMA and AMA.

CHARLES E. WORK, MD, Cincinnati; Vanderbilt University School of Medicine, Nashville, TN, 1935; age 80; died May 13, 1991; member OSMA and AMA.



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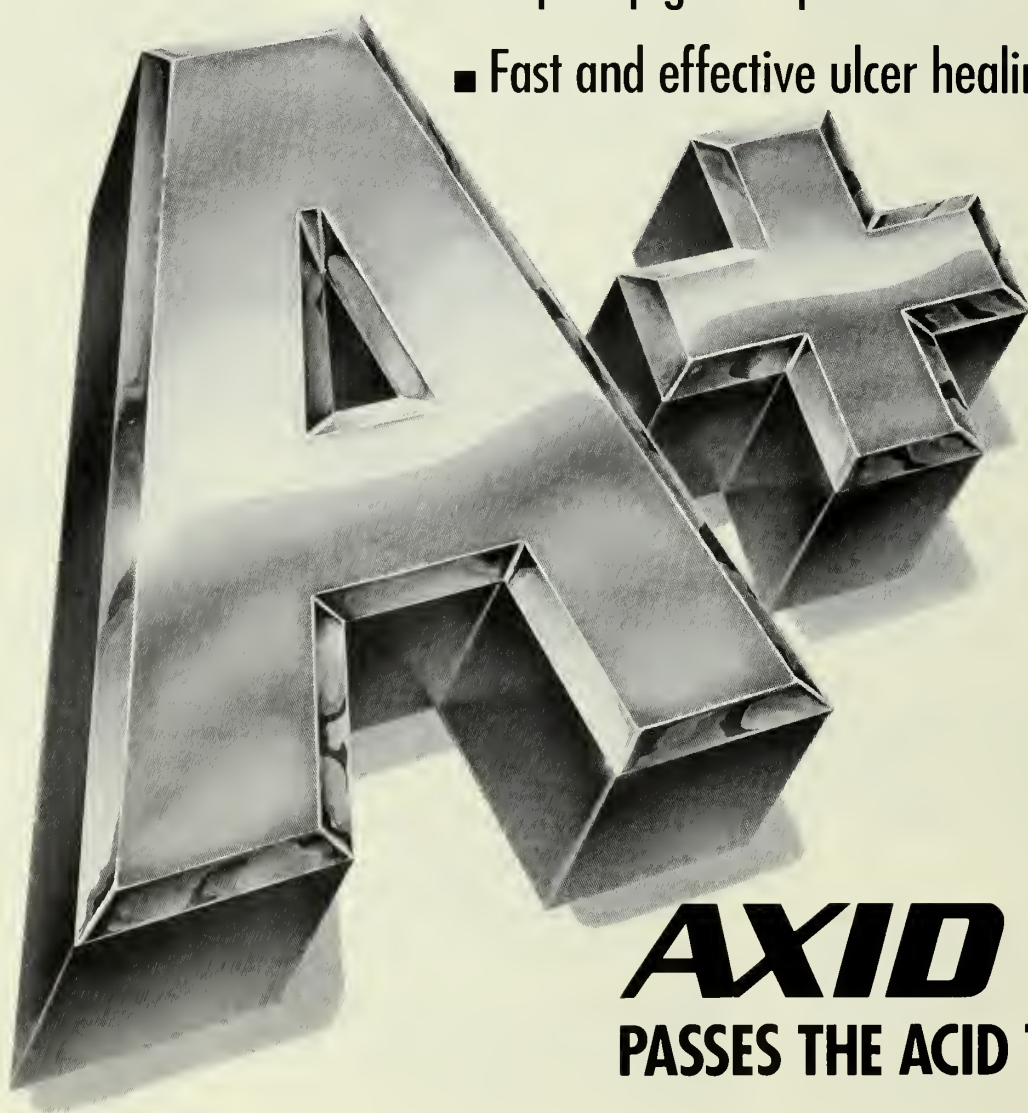
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Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, prenatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spinal bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, there was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since marked introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antihandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported. Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

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References

1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol* 1987;22(suppl 136):61-70.
3. *Scand J Gastroenterol* 1987;22(suppl 136):47-55.
4. *Am J Gastroenterol* 1989;84:769-774.

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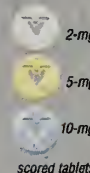
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COVER STORY

James-Jacques-Joseph Tissot achieved great success early in his career as a fashionable painter of portraits in Paris and later in London capped his career with an enormously popular series of illustrations of Biblical themes. The painting on the cover, *London Visitors*, depicts tourists on the steps of the National Gallery in London. Story on Page 512.

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Time to Pay the Bill

BENEFITS OF

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Physicians are like most people I know. They dread the idea of paying bills. They are one of the necessary evils of our lives, and every time we get one, either consciously or subconsciously, we always question the value of what we're paying for.

Every year about this time, most members of the OSMA receive that familiar notice stating that it's time to pay next year's dues. I hope that you will pay it promptly and without question, realizing the value that

you are getting for your buck. But I know many of you probably question what you receive in return for your dues dollar. Just like any other bill, you want to see evidence that your money is being well spent.

For those of you who have paid, for those of you who have yet to pay, and especially for those of who are contemplating not paying,

this column is intended to remind you just what kind of bargain you are getting for your OSMA dues dollar.

The primary product that the OSMA provides its members is representation. No one physician in this state can do all of the things for himself or herself that the OSMA does for all of us. Your voice and that of organized medicine at the Statehouse, before third-party payors and in the news media is the Ohio State Medical Association. Your dues finance efforts to support or fight legislation that affects the practice of medicine. Your dues allow the OSMA to raise your concerns before the administration of Medicare, Medicaid and other third-party insurance carriers. Your dues give us the ability to tell the public about the activities and concerns of the OSMA and react when organized medicine is negatively depicted in the news media.

Your dues allow you to be part of all of this. As an OSMA member you have the right to have your voice heard and to be counted as a part of the collective force of organized medicine in Ohio.

Just as important as representation, the OSMA offers its members information. You receive information about the association's activities at the Statehouse, its work with third-party payors and all other issues in our monthly publications. In addition, you can

**Joseph Sudimack,
Jr., MD**
OSMA President



Presidential Perspectives

call or write to receive more information about any of the OSMA's activities, benefits or services. Our staff will answer your questions about legislation help, straighten out your problems with insurance companies or give you information about any of the many member services. The call is toll-free: (800) 766-OSMA. Use it once and I guarantee you'll realize what a valuable information resource your association is.

Your dues dollars also afford you access to legal advisory services, marketing services, reference material and the very important Physicians Effectiveness Program for impaired physicians. In addition, your membership allows you to take advantage of personal and professional insurance services, leasing programs, and programs for bank cards and other financial services.

One new program that really will make your dues dollar pay off is the formation of workers' compensation group insurance by the OSMA. Members will be able to join a group composed entirely of physicians and their staffs and realize Workers' Comp premium savings of some 60% to 70%. For most members, these savings will be more than enough to cover the cost of annual association dues. But this program, just like all the rest, is for members only.

Probably the most important return you can get for your dues investment is the opportunity to say that you're a part of organized medicine. As a member, you're part of the professional chorus that speaks for quality health care for their patients. Your profession, your practice, your patients and the overall quality of health care are at stake in the present, medically hostile environment, but with your support, we intend to

ensure economic quality medical care for Ohio citizens.

I remember the days when joining your county medical society, the Ohio State Medical Association and the AMA was practically considered right of passage in the profession. It was the common bond that held our profession together in our communities, our state and throughout the country. We paid our dues to be part of "the club."

Today things have changed — but for the better. We still join our professional association as a means of establishing a common bond with our colleagues, but now it

means so much more. The activities, the services and the benefits are for you, to serve you personally and professionally.

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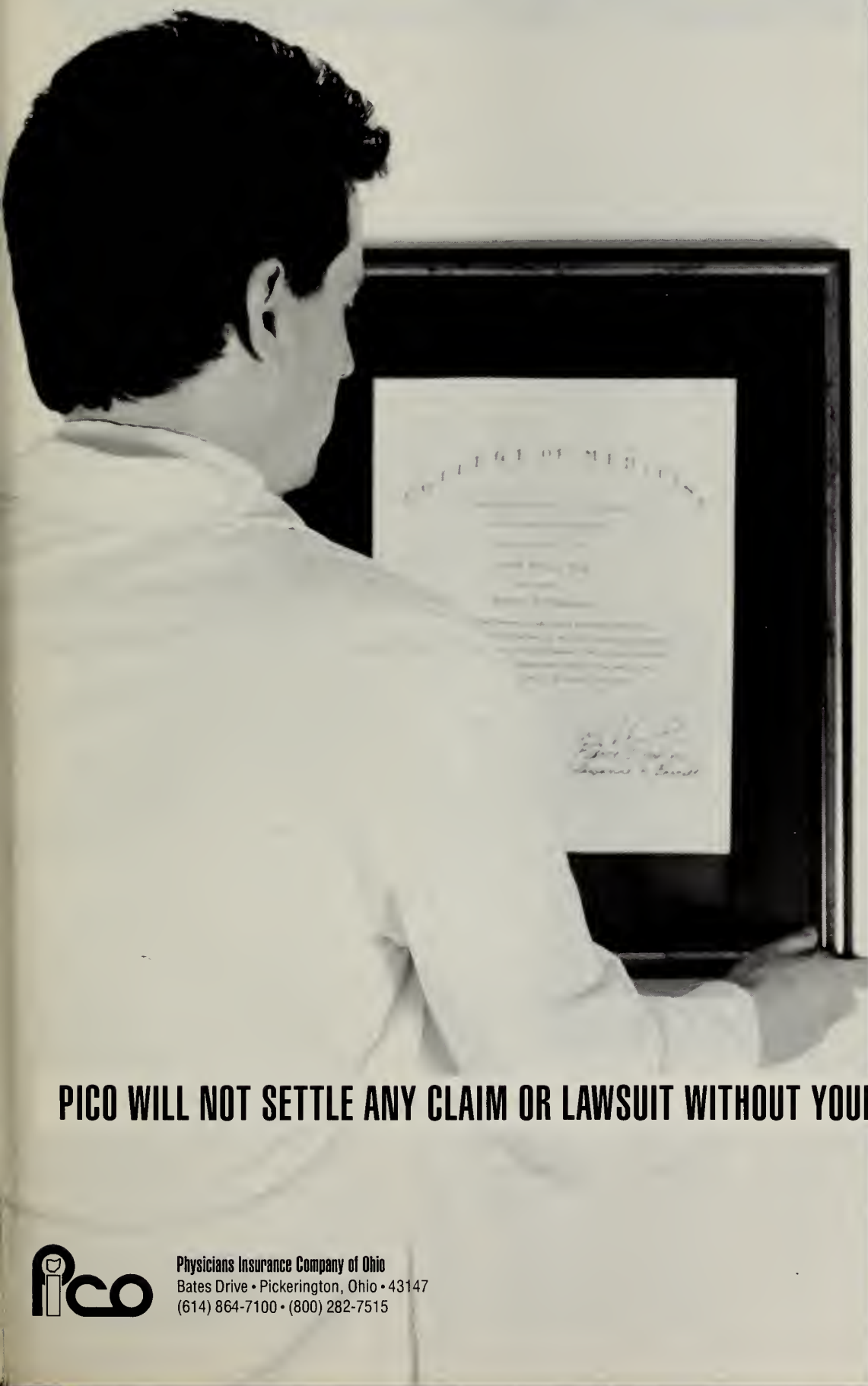
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The Future of Science and Medicine

"My interest is in the future because I am going to spend the rest of my life there."

— Charles F. Kettering

**By James
Ravin, MD**
Chair of Art and
Culture Committee
Member of OHIO
Medicine's
Advisory Board



What will be the great inventions and discoveries of the next century? As

Kettering, the famous Dayton, Ohio, inventor and General Motors executive pointed out, we should all be extremely interested in this question.

Forecasting future developments has always

been difficult. Most futurologists simply expand on present technology in their predictions and are unable to give a clear idea of what innovations will occur. This should not be too surprising, since many inventions and discoveries have been serendipitous.

At the beginning of this century, several eminent scientists were asked to predict what would be the greatest achievements of the next

100 years. Their answers merit our consideration. Some of their replies were very close to the mark, while others appear humorous in view of conditions in the last few years of the 20th century.

Thomas Bryant, a past president of the Royal College of Surgeons, recalled an eminent surgeon who felt that the acme of scientific achievement had been reached and that medical science had gone about as far as it was possible to go. However, that statement was soon proven erroneous. Bryant noted the two great advances of the first half of the 19th century were anesthesia and antisepsis, and felt the end of possibilities in those areas may have been reached. Certainly he was not correct in that regard. He correctly stated that recent bacteriologic work "clearly foreshadows both the prevention and cure of diseases that are now generally regarded as hopeless." He felt that tuberculosis, plague, and even cancer, which were formerly regarded as hopeless, had a high likelihood of successful treatment in the 20th century. He also

From Our Editors

predicted that prevention of malaria would be achieved. The new discovery of X-rays proved to him that it is difficult to say what achievements in science will occur, since the discovery of X-rays was totally unpredicted. He felt that there was no doubt that X-rays would facilitate the diagnosis of disease and bring about great achievements in medicine. Humorously, he suggested that the medical profession was undermining itself in all directions, so that in the next century it might become necessary to introduce the Chinese plan of medical reimbursement. That is, to pay doctors so long as they keep their patients in good health.

Sir William Crookes, an early worker with radiation, accurately forecast that homes would be interconnected by telephone, and the phonograph would be in common use. He felt certain that cities would not be domed-over artificially to keep out the weather. He felt that a machine for flying almost certainly would be perfected in the 20th century. He predicted that aerial navigation would be only a matter of money, that if government would devote enough funds, a solution would soon be achieved. Crookes said that very often the unexpected happens. After the recent invention of the telephone and discovery of radium, scientists had become very chary of using the word impossible.

J.W. Swan, a worker in the field of energy, predicted that a greatest achievement of the 20th century could be the development of new methods of generating electricity. He predicted that general use of electric lights and other appliances

would be common, but that the great impediment to this would be cost of power. "But I don't think it likely that it will be found advantageous for, say, cleaning our windows and scrubbing the floors of our houses, as imaginative writers have suggested . . . nor would I dare to commit myself to the opinion that, in the next century, electricity will entirely supersede gas as an illuminant."

The renowned French scientist Berthelot predicted that the greatest scientific achievement of the 20th century would be the chemical manufacture of food. This would be preceded by revolutionary changes in power. Berthelot felt power would be generated from the heat of the sun and the heat of the core of the earth.

Sir Henry Roscoe, past president of the Chemical Society, noted that science had solved the problem of refrigeration but, concerning transportation, he saw no means by which transatlantic voyages could be reduced to anything close to one day in duration. Regarding new sources of power, he recognized that many individuals were working on harnessing the tides, but he saw no efficient way to accomplish that goal.

Sir Norman Lockyer, the director of the Solar Physics observatory, felt that the most valuable contributions to science in the next century would be made in America, rather than in England or in Germany. He felt that work in evaluating the spectra of sun spots would be of help in forecasting weather changes and famine and drought in Asia and Australia. He noted that basic

scientific research is difficult for governments and people generally to care about. Therefore, they are not willing to spend money on it. As an example, he showed how Marconi, when doing theoretic studies, had little interest for anyone until he proved that wireless telegraphy was possible. Then governments and the public flocked to him. Lockyer said, "You may take it as a general rule, however, that the seemingly useless in science which ultimately turns out to be the most useful."

Sir W. H. Preece, who shared the invention of wireless telegraphy with Marconi, noted, "In science as in many other things, it is the unexpected which always happens. I have no doubt that in my own mind that, in the 20th, science will eclipse its record of the 19th century: that the people of 2000 A.D. will smile at our achievements as we smile at those of 1800." He felt that coming events do not cast their shadows before as a rule. For the telegraph, the telephone and the phonograph, there was no information that these would be great advances. Preece felt that there was no possibility of 20th century man flying. He felt that "if we are to have a real flying machine it must be based on some entirely new principle, at present altogether beyond our conception."

Sir J. W. Barry, an engineer, noted that engineering had made great advances in the last few decades of the 19th century, including the Suez Canal. He felt that engineering will help solve traffic problems in major cities. Regarding a tunnel through the English Channel, he said, "This tunnel might certainly be an

From Our Editors

achievement of the new century if were thought commercially and politically advisable." He also felt that a tunnel under the Irish Channel could be accomplished.

At the end of the 19th century, scientists congratulated themselves

on that century's many achievements. Railways, steamships, the telegraph, telephone, electric lighting, the phonograph, motorized vehicles and X-rays had all been new achievements. Most were optimistic

about the future. Nearly a century later, scientists are still optimistic about the next century. **OSMA**

1. Dolman F: Science in the New Century. What Will Be Its Greatest Achievements? *Strand* 1901; 21: 57-65.

Editor's note: Deans of Ohio's medical schools were given a copy of Dr. Ravin's article and asked to project their own ideas about the future of medical education. Three schools had replied by deadline. Their responses follow.

The Ohio State University . . .

The practice of medicine has changed dramatically over the past several years, particularly in financing health costs, technology, and hospital practice. The traditional medical school curriculum has changed little, and there is a widening gap between how medicine is practiced and how it is taught. For example, medicine has moved from largely an inpatient delivery system to outpatient care. Seventy-five percent of clinical instruction for most students is still conducted in inpatient settings. Accordingly, medical faculty members have a number of interesting challenges and opportunities.

Educating students must keep pace with changes in society as well as medicine. As our society ages and our demographics change, all physicians will need to have an understanding of geriatric medicine. Substance abuse and medical problems related to it will continue to be a burden on our

health-care delivery system. Patients with chronic disease — AIDS, arthritis, diabetes — will need increasingly coordinated care from medical professionals.

Technology, whether related to instrumentation or searching through the medical literature, will continue to move medicine toward high-tech frontiers. Students will need to be very conversant with computers and information systems.

How will medical education change? Problem solving — dealing with new information and new questions — will predominate, far overshadowing the need to memorize facts that may be obsolete by the time students begin practice. Twenty years from now, medical schools will be problem-based. Computers, as both informational and instructional tools, will be an integrated part of the medical school experience. Simulated or standardized patients will provide opportunities for students to acquire and practice clinical skills beginning with their first year. Advanced understanding of high technology such as MRI scans will be essential.

New content and strategies cannot simply be added to an already overcrowded curriculum. Instead, some hard decisions must be made about what can be eliminated or taught in different ways from the existing content.

In envisioning educational change for a new era in medicine, one area of learning, however, is constant — the doctor-patient relationship. The ability of a physician to relate to his or her patients — to discover problems and work with patients to resolve them — will never be a lost art. In fact, in a high-tech, depersonalized, consumer-centered world, it will become an even stronger base for the practice of medicine.

Our profession has been a respected one for over 2,000 years. We thrive on change; otherwise the academic life would be a predictable and relatively boring one. We see as our major mission to prepare our students for those predictable and unpredictable changes that will occur in medicine while emphasizing the critical characteristics inherent in a humane and effective doctor-patient relationship.

Manuel Tzagournis, MD
Dean
Seth Kantor, MD
Associate Dean

From Our Editors

University of Cincinnati . . .

As medical education moves into the 21st century, it will be influenced and guided by a number of forces. These forces will include a more diverse student applicant pool, a continuing rapid growth in scientific knowledge and technology, changing societal values, and economic constraints.

Recent trends show that medical schools are now seeking and admitting entering classes that reflect more varied backgrounds.

Cultural, racial and ethnic diversity is increasing among those students applying to medical school. In addition, applicants now include many older students, some of whom are married and have children. In recent years, the number of women entering some medical schools is greater than half of the freshman class. Some medical schools have dropped specific premedical course requirements, thereby encouraging students with backgrounds in the humanities and other areas of study to consider medicine. These changes are positive ones and will result in the profession being able to respond effectively to the needs of tomorrow's society. However, these changing trends will also place new demands upon medical schools to provide the resources necessary to respond to the needs of a diverse student body and to enhance the prospects of academic and professional success of all students. It is likely that medical schools will have to develop additional curriculum options for students with different personal, educational and learning needs.

In the area of curriculum, medical schools will continue to be faced with the growing dilemma of preparing students today to



practice medicine premised upon the scientific information of tomorrow. This challenge will require that medical education shift more emphasis from teaching scientific facts to empowering students to assume greater responsibility for continued learning. Educational methodology will shift from an emphasis on the learning of detailed content to developing integrative and problem-solving skills. Students will have greater need to learn efficient methods of information retrieval, i.e. library searches, computer data bases, etc. Computer literacy will become essential as computer expert systems become routine as an aid in diagnostic and patient management.

Medical schools will continue to teach information necessary for students to build a solid foundation. However, issues that in the past have received less formal emphasis will surface to take on a larger role in a curriculum. Today's medical students need to be prepared to make hard choices and decisions in a very complex medical world. For example, technological progress in areas such as genetic engineering and sophisticated treatment

alternatives, now offers new hope for many complicated medical problems but has also created both ethical and economic dilemmas that must be considered in the medical decision-making process. Understanding scientific and technical information is no longer enough; there must be an understanding of the legal, moral and economic implications as well. In addition, medical education will need to emphasize the economic realities of medicine so that future physicians will be able to make responsible decisions regarding patient care and provide leadership in the direction of health-care delivery systems.

In summary, medical education must face the challenge of preparing students to be effective physicians at a time when economics, technology and biomedical knowledge will be significantly different from that of today.

Dorothy H. Air
Assistant Dean for Student Affairs

J. Robert Suriano
Associate Dean for Student Affairs and Admissions

From Our Editors

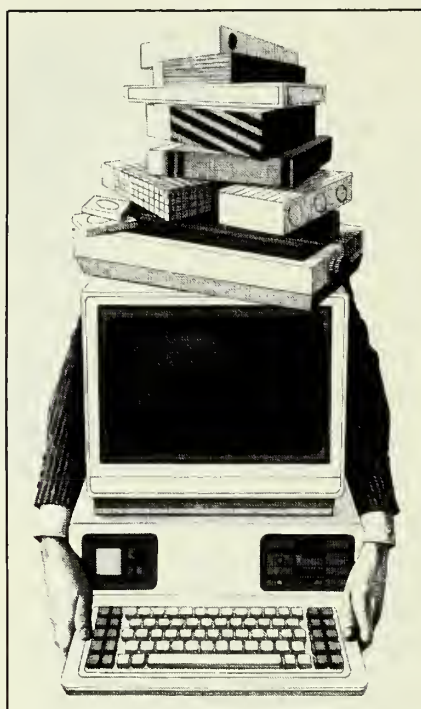
Wright State University . . .

There are a number of developments in health-care science and in health-care delivery that are presently causing significant changes in the way that medical students are taught and will likely continue to cause even greater changes in the next decade. Some areas of major development include disease prevention, medical informatics, geriatric medicine, clinical pharmacology, humanistic medicine, molecular genetics and problem-based learning.

Disease prevention will be emphasized throughout the medical student curriculum but especially during primary care rotations since we now know that most premature death from disease in this country is preventable and the public is becoming more cognizant of health promotion issues. The scientific basis for interventions to prevent disease has and will receive increased attention since the landmark national report of the U.S. Preventive Services Task Force.

Medical informatics, or information storage and retrieval to help in clinical decision-making for preventive and curative interventions, is becoming essential in an age of information overload. The use of computers for bibliographic search, drug-drug interactions and to help in clinical decision-making is becoming an increasing part of medical school education and will likely be completely integrated into the curriculum by the year 2000. As the move from inpatient to ambulatory care continues, networks of information will be established.

Geriatric medicine, by the year 2000, will be a required specific



rotation in all medical schools due to the rapidly increasing knowledge base that is developing in this area and the enormous need for skilled health-care delivery in this expanding age group. Most elderly will be treated in outpatient settings.

Clinical pharmacology will be taught to a greater degree on all clinical rotations given the large number of drug-drug, drug-person and drug-food interactions that have become evident as the number of medications continually expands and quality assurance protocols become more prevalent in ambulatory settings.

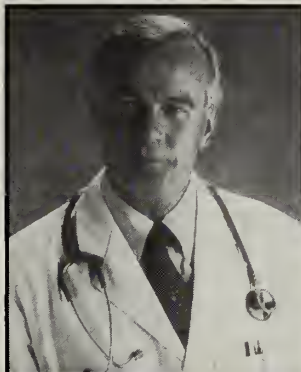
Humanistic medicine will gain momentum in all schools as the knowledge from the social sciences is applied with greater fidelity to teaching interviewing skills and the doctor-patient relationship. Understanding the culture of individuals with great diversity will become increasingly important as the demography of this country continues to change.

Molecular genetics experiments in discovering the human genome, applying recombinant DNA technology and screening and repairing genetic abnormalities will ultimately raise significant ethical questions that will make previous questions pale by comparison. Students will need to know the scientific basis as well as ethical implications of ethical experiments, and the information overload of a rapidly expanding science will likely become problematic.

Finally, to help address a rapidly expanding data base **new methods of reaching** will continue to be employed. For example, there will be a greater emphasis on case-based and problem-based teaching, in both hospital and outpatient settings, which is more student-oriented but probably not sufficient relief from excessive lectures in the basic sciences. The advances in medical education that are emerging today and in this decade will probably not be fully appreciated until 2010, if then, when there will occur a proper proportion and use of multiple educational methods.

Kim Goldenberg, MD
Dean

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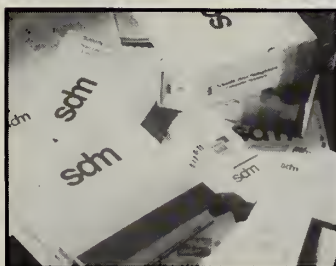
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Association News

McAfee discusses AMA priority issues

Executives from county medical societies across the state convened this past summer for a chance to discuss some of medicine's top issues for 1991 and 1992.

Leading the discussion was Robert McAfee, MD, an AMA Board of Trustee member from Maine, who addressed AMA's current priority issues. They included:

RBRVS

This item has risen quickly to the top of AMA's agenda, since it will affect how physicians will be paid in the future. "That's why we need to get it right," says McAfee. "That's why it is a critical issue for us."

Originally, the principles of RBRVS had to do with budget neutrality and both the OSMA and the AMA supported physician payment reform, proposed under RBRVS, based on assurances from Congress that the reform would be implemented on these principles. HCFA's rules, however, propose to cut the Medicare payment system by 16% over the five-year phase-in of RBRVS.

Dr. McAfee said the AMA has already approached HCFA about the illegality of its rules and is presently examining other options that will prevent the proposed reform from being implemented by January. However, the White House is looking to reduce its expenditure and has targeted this area, said Dr. McAfee. "Gail Wilensky of HCFA commented in an article for the *AMNews* that we will need to show them where we'll save \$5 million to \$6 million if this proposal is thrown out."

JCAH surveys

Expect to see some changes in



Organizations support PEP

The Physician Effectiveness Program inaugurated its full-time professional operation on September 1, 1991 — thanks to generous contributions by five organizations. Major contributors included The PIE Mutual Insurance Company, represented by President and Chief Executive Officer Larry E. Rogers, third from left; OSMA and the Ohio Medical Education & Research Foundation (OMERF), represented by Edward T. Carden, MD, second from left, chair of the Physician Effectiveness Committee and OMERF board member; Physicians Insurance Company of Ohio (PICO), represented by President and Chief Executive Officer Robert L. Dion, right; and the Ohio Hospital Insurance Company (OHIC), represented by Senior Vice President Ronald D. Wade, left. Second from right is Richard O. Pelham, MD, medical director for PEP's new professional program.

the JCAH accreditation process in the future, said Dr. McAfee, who added that the changes will make "physicians come to love us."

One such change will be the slant of JCAH's accreditation process. "It will change from a paper trail survey process to an outcome orientation process, focusing on how the patients do," he said. In other words, the question will no longer be *can* this facility give quality care but *does* it?

Professionalism

The AMA is becoming increasingly concerned about the perceived lack of professionalism in the practice of medicine — a loss Dr. McAfee attributes to FTC's charge to physicians to advertise.

"It changed our code of ethics under a court order," Dr. McAfee said, "and now physician marketing and the business side of medicine is what predominates in the eye of the public" — which, he added, no longer perceives its physicians as caring professionals.

To compensate, Dr. McAfee said that the AMA may soon ask all those in organized medicine to abide by a certain code of ethics.

"Members of organized medicine will then be distinct from those who are not," said Dr. McAfee, "because its members will hold a certain level of professionalism. Then we'll advertise that image to the media."

AIDS

While the AIDS hysteria

Association News

continues, calling for mandatory HIV testing of physicians, Dr. McAfee pointed out two reasons why AIDS testing is a good idea for *anyone* who may have been exposed to the HIV virus.

1. The symptom-free interval can be lengthened with the use of AZT. "It's a reason to identify those who are affected early on," says Dr. McAfee. "We can offer help now — not just discrimination."

2. Vaccines can be given to those who are infected and the course of their illness can be improved.

As far as mandated testing, however, he quickly pointed out that no physician-to-patient transmission of AIDS has ever been documented in this country — but physicians can probably expect to see a law mandating HIV testing for physicians soon.

Violence in society

The AMA will announce a major stand against violence in this country sometime this fall.

Drug and alcohol abuse for example, are preventable, social problems that can lead to homicide on one extreme, teenage pregnancy on the other, said Dr. McAfee.

"Compounding these problems is the fact that often, care for these victims is uncompensated," he continued, adding that explains, in part, the reasons for this country's high health-care costs.

"The time to tackle this problem is now," he said.

Health-care reform

Dr. McAfee pointed out three factors that should be kept in mind regarding Canada's health-care system:

1. Canada's technology is strictly controlled, and these restraints have limited the practice of medicine in that country.

2. Canada's postgraduate medical courses are no longer as outstanding as they once were.

3. Canada's "free" health care is passed onto Canadians in other ways, primarily through taxes on such products as milk, which in New Brunswick, for example, costs \$11.24 a gallon.

"Canada can't afford a free health-care system much longer," he says.

Care vs. caring

"Patients don't understand what quality of care is all about, but they are concerned with the quality of caring," said Dr. McAfee.

He went on to say that 50 years ago, caring — the ability to empathize with the patient — was all the physician had. There was no technology and few antibiotics. Then, the only thing people expected from their physicians was care — not a cure. Now, of course, those expectations have changed. "We have created an image that we can cure things we can't. We need to go back to a system that provides a caring atmosphere," said Dr. McAfee. "Whatever direction the health-care system will go in the future, if it doesn't involve caring, it won't work." OSMA

Continuing Medical Education

Cardiology Update — 1991 . . .
Oct. 4-5 . . . Rhodes Hall Auditorium, Ohio State University Hospitals, Columbus . . . 800-492-4445.

Gastroenterology Update . . .
Oct. 12-13 . . . Hyatt on Capitol Square, Columbus . . . 800-492-4445.

The New Anti-Depressants . . .
Oct. 26 . . . Hyatt on Capitol Square, Columbus . . . 800-492-4445.

Stepping Ahead With the New I.D.E.A., 2nd annual state conference of the Autism Society of Ohio . . . Nov. 1-2 . . . Stouffer Dublin Hotel, Dublin . . . 216-656-9068.

Update in Diabetes . . . Nov. 7 . . . Cleveland Clinic Foundation, Bunts Auditorium, 9500 Euclid Ave., Cleveland . . . 800-762-8173.

AIDS: Interprofessional Collaboration and the Delivery of Services . . . Nov. 8 . . . Ramada University Hotel, Columbus . . . 614-292-5621.

Non-Pharmacological Approach to Prevention and Treatment of Diseases . . . Nov. 9-10 . . . Holiday Inn on the Lane, Columbus . . . 800-492-4445.

Gastroenterology Update . . .
Nov. 13-14 . . . Cleveland Clinic Foundation, Bunts Auditorium, 9500 Euclid Ave., Cleveland . . . 800-762-8173.

Colorectal Surgery Update . . .
Nov. 15-16 . . . Cleveland Clinic Foundation, Bunts Auditorium, 9500 Euclid Ave., Cleveland . . . 800-762-8173.

Association News

Group rating saves Workers' Comp premiums

Savings are in the mail for physicians who were accepted in the new OSMA Workers' Compensation Group Rating Program. According to Jerry Campbell, director of the OSMA Department of Development and Member Services, contracts were mailed the end of September.

Campbell is encouraging those physicians to "sign the contract and return it as soon as possible in order to be enrolled in the program." He points out that return of the initial letter of authority does not automatically enter a physician into the program.

For those physicians who did not participate in the initial feasibility study the opportunity to do so in the second year of the program will be available, since each year the OSMA Workers' Compensation group rating program will be re-formed.

Those who were fortunate enough to get involved this year will realize savings between 30% and 60%.

The new Workers' Compensation premium rates go into effect on July 1, 1992 and will be reflected in Workers' Compensation premium billings effective January 1, 1993.

All of this was made possible by a change in the Ohio Workers' Compensation Law — by enactment of House Bill 222, which became effective during the last quarter of 1990 — permitting associations to pool or group their members under one plan for the purpose of rating their Workers' Compensation risk. This group rating program rates physicians and will significantly lower the premium physicians are now

paying for themselves and for their employees.

The OSMA, along with the actuarial firm of Frank Gates Service Company and the consulting firm of Carl Craig Company, conducted a feasibility study to determine the maximum benefit for OSMA members. More than 7,300 Ohio physicians indicated an interest in participating in the new OSMA Workers' Compensation premium

savings plan.

Membership in a county medical society and the OSMA is a mandatory requirement to benefit from the new program. Campbell explains that pre-grouping studies show that the greater the participation the greater the possible savings. "As an OSMA member participating in the OSMA group rating program, you might save your annual OSMA membership dues," says Campbell.

Colleagues

The Ohio Academy of Family Physicians recently installed **Gene E. Wright, MD**, Lima as its president; **Ross R. Black II, MD**, Cuyahoga Falls as president-elect; **Roger D. Jenkins, MD**, Lima, as vice-president; **A. Patrick Jonas, MD**, Columbus, as treasurer; **Sally A. Abbott, MD**, Springfield, as speaker; and **Kenneth R. Bertka, MD**, as vice-speaker.

In addition, the OAFP selected **Nino M. Camardese, MD**, Norwalk, as Ohio Family Physician of the Year, an award presented annually to an Ohio family physician who exemplifies the highest standards of professional and community service. **Wilburn Weddington, MD**, Columbus, was named the OAFP's Educator of the Year, an award presented annually to a physician who has made outstanding contributions to the education of Ohio's future family doctors.

Herman I. Abromowitz, MD, Dayton, was recently elected president of the Organization of State Medical Association Presidents. This



Abromowitz

organization is composed of presidents, presidents-elect and past-presidents of all of the state medical associations. The group meets twice a year, generally during AMA meetings (although the group is not affiliated with the AMA) for educational purposes and for networking opportunities.

Alvin Crawford, MD, Cincinnati, has received an award from the American Orthopedic Association for his work in pediatric orthopedics and neurofibromatosis in children.

John Bullock, MD, Kettering, has been elected president of the International Society for Orbital Disorders.

Jane Uva, a third-year medical student at Wright State University School of Medicine, was elected to the AMA's Medical Student Section Governing Council for the 1991-1992 academic year.



Uva

Association News

Ohio is fortunate to be one of only six states (the others include Washington, Nevada, Wyoming, North Dakota and West Virginia) eligible to offer a group rating program like this.

Ohio physicians need to get busy. They have until Nov. 1, 1991 to complete and return their contracts.

For more information on this program contact Jerry Campbell, director of the OSMA Department of Development and Member Services, at (800) 766-OSMA. **OSMA**



President addresses OAFP

Joseph Sudimack, Jr., MD, president of the OSMA, addresses the Ohio Academy of Family Physicians. The OAFP met in Columbus August 9-11.

Mini-internship pairs physicians, community leaders

The Lake County Medical Society, with the cooperation of Lake Hospital System, recently conducted its third annual mini-internship program, which pairs physicians with business and community leaders. For a 24-hour period seven interns representing the areas of law, politics, business and clergy accompanied physicians as they made rounds, office calls, handled emergencies and performed surgery.

The mini-internship program was started by Janet Blanchard, MD, three years ago to improve communication between medical practitioners and the general public.

In the coming months, the tables will be turned, and the physicians will spend a day with their respective intern. **OSMA**



Janet Blanchard, MD, right, a Lake Hospital System plastic and reconstructive surgeon, and a physician's assistant show Lake County Commissioner Robert Gardner, left, what surgery is really like.

The Caring Medical Family

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On a lovely autumn day in Chicago, after National Auxiliary leadership meetings, Michigan Avenue was full of

By Joyce E. Penn
OSMA Auxiliary
President



handsomely dressed people shopping and hurrying to various places. A gray-haired woman about 60 years old, shabbily dressed, stepped off the curb and looked lonely, hungry and desperate.

She watched the busy pedestrians sadly, with the same weary look as the man sitting in a doorway a few feet away. With shaky hands and filthy clothes he clutched a bottle of wine, the poison that passers-by had given him with their coins.

Do you ever wonder how Americans reached this point, where we calmly accept the fact

that we cannot deal effectively with scores of thousands of destitute Americans who suffer silently, often mentally and physically ill, in the streets where we send them to live? It is a disservice to all the homeless to lump their problems together as unsolvable. They have many needs, including basic medical care.

Our newspapers are full of grim statistics: more than 37 million uninsured in the United States, 1.4 million in Ohio, with 30% of these children. The working poor and the homeless are grouped together in these statistics.

Several medical societies in Ohio counties, assisted by their auxiliaries confront the suffering on their doorsteps with practical solutions, providing regular health care to the working poor and homeless shelters. For example, Drs. Thomas Helmrath and Owen Johnson, physicians in the Academy of Medicine of Columbus and Franklin County, were instrumental in instituting the academy's physician volunteer program, in conjunction with The Auxiliary to the Academy of Medicine of Columbus and Franklin County. Designed to provide free primary office health care in three Columbus health centers, the volunteers act as the liaison staff and provide support materials for the evening clinics. Auxilian nurses give inoculations,

Auxiliary Page

immunizations, and provide general nursing care. Lay auxiliaries provide needed office services. This program, instituted seven months ago, will, we hope, expand coverage into the other four health centers in Columbus, in the future.

One legislator, state Sen. Richard Pfeiffer, in an attempt to ensure access to health care among homeless persons, has proposed Senate Bill 184. Suggested by Dr. Pedro Obregon, a general surgeon in Columbus, this legislation provides immunity to health-care professionals working on a voluntary basis in homeless shelters. If enacted, physicians will provide needed services free of malpractice concerns.

Dr. Obregon instituted the voluntary care program that four physicians regularly provide at the Open Shelter and the Homeless Family Foundation in Columbus. Family practice residents and pediatric residents from area hospitals provide needed assistance. Prescribed medications are difficult to procure for the patients although many physician offices save pharmacy samples for the centers.

In Montgomery County, a team of physicians, spearheaded by Dr. Steven Swedlund, staff Boothe House, a homeless shelter, and Saint Vincents de Paul in Dayton. Tending to busy daytime medical practices, these doctors and others in Ohio end their long days providing front line health-care services for Ohio's uninsured. They hope to circumvent expensive and costly emergency medical care for their patients by emphasizing preventive medicine.

Historically, doctors have always cared for their poor patients. In the 1950s, residents and student nurses worked on hospital units, designated as "clinical." Funded by city and county welfare systems,

many of the indigents' health-care needs were solved. It seemed like everyone shared in health care for the poor and considered it their responsibility.

With the advent of Medicare/Medicaid and climbing federal and state budgets, other services competed with the same dollar paying for health care. The level of annual income to qualify for Medicaid treatment in Ohio has been raised each year, thereby decreasing the number of eligible people. Many hospitals can no longer carry the weight of their indigent care and no alternative system exists for their care.

Americans support the theory that government should provide some fundamental level of necessary health care. The major

barrier to decision and change is fear: fear that the price tag to cover medical care for the uninsured will be too high and impossible to control. No acceptable plan is likely without agreement about how to contain its costs. Some legislators may continue to advocate rationing benefits, trying to find methods to make our system perform more economically. Others, such as Sen. Pfeiffer, address areas of concern by working diligently with the medical profession, abolishing obstacles to indigent medical care. While the experts search for utopian solutions at affordable prices, the caring medical family will continue to donate its time and expertise to help the poor and homeless in Ohio communities. **OSMA**



Sources for Clinical Clips

- Adult diabetes *Cincinnati Enquirer*,
July 18, 1991
- Lung cancer *Elyria Chronicle Telegram*,
July 16, 1991
- Babies of teen mothers March of Dimes Birth
Defects Foundation
- Heart failure *Toledo Blade*,
August 1, 1991

Legislation

“Anti-hassle II” introduced in Congress

Federal legislation to cut back further on the administrative hassles involved in treating Medicare patients has been introduced by Rep. Roy Rowland (D-GA) and Sen. Max Baucus (D-MT). HR 2695 and S 1332 follows the enactment last year of AMA's “anti-hassle” legislation, but this year's proposal goes further to address problems in the following areas:

- Medicare secondary payor would prohibit HCFA from denying physician payments for medically necessary covered services if patients fail to complete questionnaires.
- Extrapolation would allow HCFA to extrapolate for case identification purposes, but give physicians the option of requiring the Medicare carrier to produce evidence of each specific payment error.
- Carrier use fees would prohibit HCFA from charging physicians for: 1) filing paper claims, 2) filing claims with errors, and 3) unsuccessful appealing of claims.
- Annual carrier evaluations would permit state medical associations to submit information to be included as part of the Medicare carrier's annual evaluation.
- Medicare carrier accountability would permit individuals who have suffered damages of at least \$500 to file appeals when the carrier has failed to implement Medicare policy.
- Physician peer review would require that all medical necessity denials under Medicare be reviewed by physicians practicing in the same specialty and

require that the physician reviewer be identified by name.

Physicians are urged to ask their U.S. representative to support this proposal by becoming a cosponsor of HR 2695 or S 1332. As of this date the following U.S. representatives from Ohio are cosponsors of HR 2695: Paul Gillmor, Marcy Kaptur, Bob McEwen, Mike Oxley and Chalmers Wylie. Physicians from their districts should express gratitude for their cosponsorship.

Hearings continue on optometry bill

Hearings on Senate Bill 110, the optometrists' bill to expand their scope of practice, continued until early July in the Ohio Senate Health and Human Services Committee. Earlier, optometrists testified that they are primary eye care providers who are well qualified to diagnose eye disease, and with some additional training, they should be allowed to prescribe therapeutic drugs.

Testifying against the bill at the most recent hearings was Richard J. Wiseley, MD, chair of the OSMA Committee on State Legislation. Dr. Wiseley emphasized that there is no evidence that Ohioans lack access to eye care by physicians; that this bill will not generate cost-competitiveness in eye care; that it will actually increase the cost of health care; and that optometrists are inadequately trained to diagnose and treat eye disease. Several former patients of optometrists also testified against the bill saying that their eye disease had not been detected by the optometrist and that only after

seeing an ophthalmologist was their disease properly diagnosed and treated.

At the direction of leadership in the Ohio Senate, discussions are now taking place between leaders of the Ohio Ophthalmological Association, the OSMA and the Ohio Optometric Association.

Medical licensure changes proposed

The Ohio House and Retirement Committee has begun hearings on House Bill 454, a bill that would make several changes in Ohio's medical practice act. Sponsored by Rep. Paul Jones of Ravenna, the bill is sought by the State Medical Board.

H.B. 454 would alter the requirements for admission to the board's examination to practice, would change the dates for renewal of physicians' licenses, and would create several types of limited licenses.

Also under the bill, graduates of international medical schools would not be required to take the test of spoken English if the IMG received their undergraduate degree from an American college or university or if they have held a license to practice medicine in another state for at least five years.

Legislation

Ohio may reinstate mandatory motorcycle helmet laws

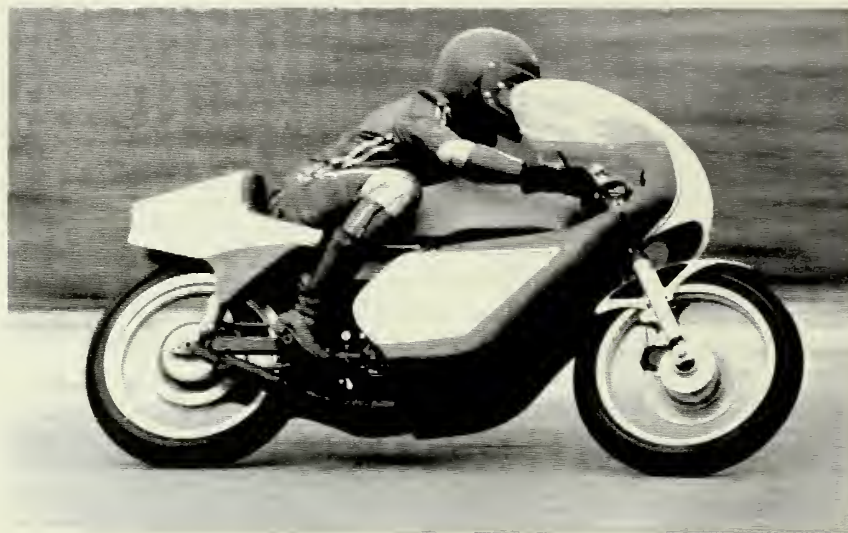
Thanks to a little-noticed section of the nation's massive transportation bill, Ohio legislators may soon be pressured into rethinking the repeal of Ohio's mandatory motorcycle helmet law, which was lifted in 1978.

The U.S. House is enticing state legislatures that have been delinquent, so far, in passing motorcycle helmet and seatbelt laws with \$95 million in highway fund incentives if they pass such safety laws by 1994. If states fail to rise to the bait by then they may instead be required to divert a portion of their highway dollars to safety programs.

Rep. Douglas Applegate (D-Steubenville) tried to pass through an amendment to this proposal that would exempt states, like Ohio, which has partial helmet laws. (Ohio requires only 16- and 17-year-olds to wear crash helmets.) The amendment was defeated in subcommittee, however, and it was not expected to be offered again on the floor of the House.

Consequently, the Ohio Legislature could soon face pressure to again mandate the use of helmets for all motorcyclists, a circumstance that would please the OSMA, which, in 1984 and again this year, voted through its House of Delegates to lobby for enforceable legislation that would mandate the use of protective headgear for all motorcycle, bicycle, all terrain vehicle, snowmobile and mobile operators and passengers in Ohio.

Since the law was lifted in 1978, motorcycle fatalities have risen across the state. In 1989, for example, Ohio had 163 motorcycle



crash fatalities, making the state the fourth in the nation for motorcycle deaths behind Texas, California and Florida — all warm weather states where motorcycling is a year-round activity. In four of the last 10 years, motorcycle fatalities in Ohio have totaled over 200.

Yet, according to both of the OSMA resolutions on this matter, studies have shown conclusively that the use of protective helmets by motorcycle operators and passengers is a significant factor in the prevention of serious injury or death due to accidents. **OSMA**

The death of hospitals?

An annual study, published jointly by Health One Corp. and Deloitte & Touche and distributed recently to senior officials from more than 50 Central Ohio hospitals, predicts that there will be no national solution to health care

for Americans in this decade.

"The assessment says there are going to be winners and losers in the health-care field in the '90s," says Ken Weixel, senior manager in health care at Deloitte & Touche's Columbus office, in recent news reports. Yet today's health-care environment is too turbulent to allow any real decisions on the issue to be made, the report concludes.

Nevertheless, predictions were made on the future of hospitals as the health-care crisis continues to grow. For example, the study said hospitals were not expected to be a part of the health industry expansion, and they are moving, even now, toward new configurations, partly because of changing patient needs. To illustrate this point, the report pointed out that outpatient services have jumped from 25% of a hospital's business five years ago to a figure that currently stands at about 44%. Within two years, the report predicts, outpatient services are expected to outnumber inpatient

Legislation

services.

As a result, industry experts predict that by 2000, nearly 40% of all U.S. hospitals will be closed or used for some alternative purpose. On the other hand, the study predicted that HMOs will have a 40% market penetration rate, and that the private sector enrolled in PPOs will leap from 20%, today's figure, to 40% by 1994.

"Managed care facilities are the answer," says one health-care consultant. **OSMA**

U.S. Senate adds AIDS amendments

The United States Senate recently added several AIDS amendments to separate bills. Two amendments were sponsored by Sen. Jesse Helms of North Carolina. One would order criminal penalties against physicians and other health professionals with AIDS who have physical contact with patients. The other Helms' amendment would permit physicians to order HIV blood tests from patients before performing invasive procedures. The third amendment would require states to enact the new Centers for Disease Control guidelines for prevention of transmission of HIV to patients. Issued July 12, 1991, the CDC guidelines recommend that those health-care professionals who test HIV positive should refrain from performing "exposure prone" procedures such as surgery.

These bills with the AIDS amendments are headed to conference committee where the House and Senate members will work out the differences. The AMA is giving the AIDS issue its top priority attention.

CDC to amend AIDS definition

The federal Centers for Disease Control (CDC) has revised its definition of AIDS, and the change could add tens of thousands of people infected with the virus to the ranks of those considered to have the disease.

The new definition will include in the AIDS caseload any HIV-infected person with a count of 200 or fewer CD4 cells, or T-cells, per cubic millimeter of blood. This immune-system cell, which in a healthy person is found at

levels of about 1,000 per cubic millimeter, is destroyed by the AIDS virus.

Dr. James W. Curran, director of the AIDS division at the CDC's National Center for Infectious Diseases, said the broader definition could add 150,000 to 200,000 people to the AIDS caseload. As of June, 182,834 AIDS cases had been reported to the agency, 116,184 of which have resulted in death.

More Legislation on page 496



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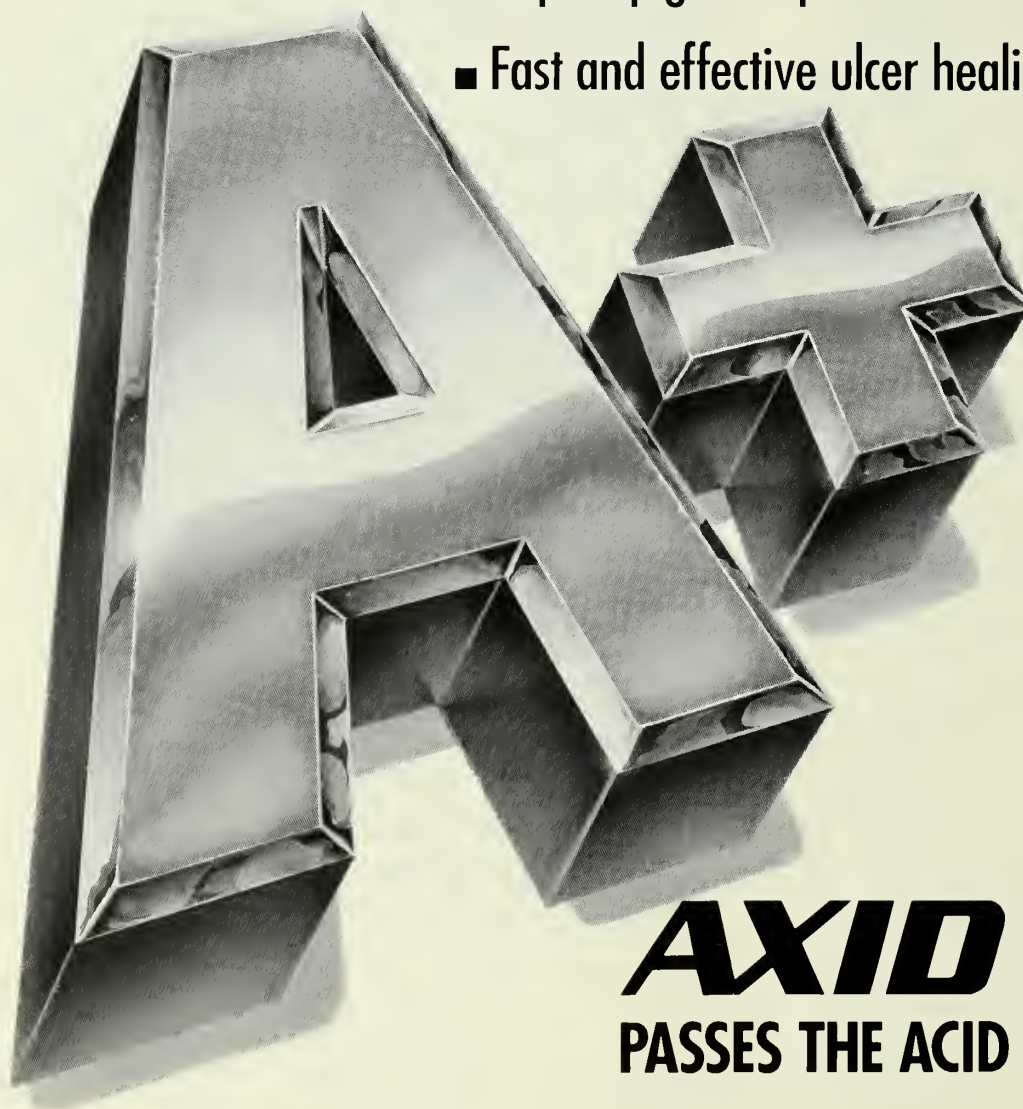
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Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.
3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests: False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions:—No interactions have been observed with theophylline, chlorazepate, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility:—A 2-year oral carcinogenesis study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C:—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spinal bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers:—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use:—Safety and effectiveness in children have not been established. Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGPT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular:—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS:—Rare cases of reversible mental confusion have been reported.

Endocrine:—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic:—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental:—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity:—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other:—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP
[091190]

References

1. Data on file, Lilly Research Laboratories.
2. Scand J Gastroenterol 1987;22(suppl 136):61-70.
3. Scand J Gastroenterol 1987;22(suppl 136):47-55.
4. Am J Gastroenterol 1989;84:769-774.

NZ-2943-B-149347

Additional information available to the profession on request

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Clinical Clips

10 million

Number of Americans afflicted by adult diabetes

6

Percentage of men who reduce their risk of diabetes by burning up 500 calories a week exercising

160,000

Number of Americans to be diagnosed with lung cancer in 1991

140,000

Number who will die from lung cancer

8th

Ranking of Ohio in lung cancer cases

7,800

Number of expected cases in Ohio

10%

Percentage of increase in birth rate for girls between the ages of 15 and 17 from 1986-1988

500,000

Number of babies born to women ages 19 and under

2,177

Number of teen births in Franklin County in 1989

60%

Percentage of teens under 15 who have a risk of dying from obstetric complications

13%

Percentage of teen-age mothers who receive no prenatal care

40,000

Number of deaths annually from chronic heart failure

10,000 to 20,000

Number of deaths that could be prevented by using drugs to relax blood vessels

Sources on Page 490

Legislation

Physician immunity bills introduced

Three bills have been introduced addressing liability concerns of physicians who volunteer services to underserved populations. House Bill 425, sponsored by Rep. Tom Watkins of Stow, would grant a qualified immunity from civil liability to physicians who voluntarily treat indigent or uninsured patients. Sen. Richard C. Pfeiffer, Jr. from Columbus, introduced Senate Bill 184 to provide a qualified immunity from civil liability for physicians who treat indigent patients in a charitable shelter. An identical measure has been introduced in the Ohio House as House Bill 469 by Rep. Joe Secrest of Cambridge. None of the measures has had a committee hearing as yet.



Audiologists agree to OSMA changes

The audiologists promoting House Bill 381 and Senate Bill 179 have agreed to amendments to address OSMA concerns. Both bills would revise speech-language pathologist and audiologist licensure laws and redefine their scopes of practice. The OSMA succeeded in winning approval of amendments to retain the ability of physicians to delegate certain speech and hearing tests to office personnel and to clarify the proper use of tests of vestibular function

and tinnitus by audiologists. Senate Bill 179 passed the Ohio Senate on August 7th and will

proceed to the House for what are expected to be expeditious hearings and quick passage.

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Science and Education

10 Years of AIDS in Ohio

The Ohio Department of Health

In June 1981, the U.S. Centers for Disease Control (CDC) published its initial report on the condition we now recognize as the acquired immunodeficiency syndrome (AIDS). By January 1, 1991, CDC had received reports of 161,073 persons in the United States meeting the CDC AIDS surveillance definition. Over approximately the same period, the Ohio Department of Health (ODH) received reports of 2,351 cases of AIDS diagnosed in Ohio residents. The epidemic in both Ohio and the nation was characterized by rapid increases in case numbers through most of the 1980s; as the decade ended, overall rates of increase slowed and in some areas appeared to stabilize. Unfortunately, where stability has occurred, there remains a high level of morbidity; in addition, there are geographic and demographic categories where rapid increases in case numbers continue even to this day. In this report, we will present a brief review of the first decade of AIDS surveillance data for Ohio and highlight some of the major trends and patterns in that data.

Incidence of AIDS in Ohio

Gender: Males accounted for 2,203 (93.7%) of Ohio case reports. The number and relative proportion of female cases increased over the decade. From 1981-1985, females accounted for 3.5% of case reports; in the 1986-1990 period, female cases were 7.0% of the Ohio total.

Age: The age pattern of Ohio AIDS patients was relatively stable through the 1980s. Approximately 88% of cases occurred in persons

between 20 and 50 years of age at diagnosis; the peak period of incidence was the 30s, with 43% of Ohio cases in that age range. Through the end of February 1991, ODH had received reports of 40 cases of AIDS in persons less than 13 years old. Over 80% of such cases were in children less than 5 years old.

Race/ethnicity: Seventy-four percent of Ohio cases have been white, 23% have been black, and 2% have been Hispanic, with less than 1% of other races. AIDS rates among black and Hispanic Ohioans are approximately three times higher than rates among white Ohioans. Males have accounted for the majority of cases in all groups, but the proportion of female cases has been much higher in the black and Hispanic categories. As the first decade of AIDS in Ohio closed,

case rates in minority group members were not only higher than case rates in whites, but increasing at a faster rate.

Geography: Four Ohio counties (Cuyahoga, Franklin, Hamilton, and Montgomery) have accounted for 63% of Ohio AIDS cases. The eight largest counties have accounted for 75% of the Ohio total. The focus of the epidemic among urban residents was a consistent pattern through the 1980s. However, this urban focus did not mean that non-metropolitan counties were spared. By the end of April 1991, there were only six Ohio counties that had not reported a case of AIDS in a resident.

Risk Factors for AIDS

Sexual behaviors: In Ohio, most cases of AIDS have occurred in men with a history of sexual



Science and Education

relations with another man. Overall, 75% of Ohio cases and 84% of the male cases gave such a history. In CDC's national data the corresponding proportions are 65% and 73%, respectively. The proportion of Ohio cases with a history of male-male sex was relatively stable through the 1980s. Residents of major metropolitan areas with AIDS were no more or less likely to have a history of homosexual or bisexual activity than AIDS cases from other parts of the state.

In the CDC classification, persons with AIDS whose only reported risk is heterosexual contact with a person known to be HIV infected or at high risk for such infection (such as intravenous drug users or bisexual men) are designated "heterosexual contact" cases. The number of such cases has been rising faster than the total AIDS count in both Ohio and across the U.S. Heterosexual contact is an uncommon risk category for men, with 1% of Ohio male cases in this category and 2% nationally. However, among Ohio women with AIDS, heterosexual contact was the most commonly cited risk category; this was particularly true for Hispanic women. Most (55%) of these women had a history of sexual relations with an IV drug user. Heterosexual contact cases are slightly less common in Ohio than nationally, but the proportion of such cases in Ohio reports increased between 1981 and 1991.

Drug abuse: Seven percent of Ohio cases reported between 1981 and 1991 had a history of illegal use of drugs by the intravenous route (IVDU) as their primary risk factor. This history was more common among females with AIDS than among men. Seven percent of adult male cases had IVDU as their primary risk, while

33% of the adult women with AIDS had such a history. In addition to the adult cases associated with personal IV drug use or sex with an IV drug user, a significant proportion of pediatric cases are linked to maternal infections associated with drug abuse. In Ohio, 38% of the cases under 13 were associated with drug abuse. In general, IV drug-associated cases in Ohio have been more common in blacks and Hispanics; this is true for both men and women.



Blood products: Until specific screening of blood for transfusion and processed blood products was initiated in 1985, there was significant transmission of HIV infection by these routes. Sixty-one cases of AIDS in Ohio residents have been linked to blood transfusions, and 71 cases have been linked to hemophilia therapy. These risk categories have accounted for 31% of Ohio's pediatric cases, and have contributed substantially to the toll among women and persons over 60.

Health-care workers: Through the end of 1990, ODH had received reports of 140 resident health-care workers with AIDS. Ninety-six percent of those cases were men and 97% had a history of one or more of the established risk factors

for AIDS. Twelve of the cases were denoted to be physicians. The proportion of AIDS cases among health-care workers nationally has closely approximated the proportion of such workers in the population, supporting the impression from other studies that occupationally related AIDS risks have not contributed substantially to the epidemic total. ODH has received no case reports in which the infection appears to be due to transmission of virus from an infected health-care worker during the performance of professional duties.

Natural History

The early pattern of rapid decline and death in persons with AIDS altered as the epidemic matured. Ohio data reveal a steady progression in the average survival after a diagnosis of AIDS. In the early 1980s, survivals of six months or less were the norm. By the late 1980s, this average survival had tripled and preliminary figures for the most recent cases suggest that average survivals continue to climb. Unlike the pattern in national data, risk category has not been a major predictor of survival in Ohio cases. In Ohio, the date and age at diagnosis have been the significant predictors of survival, with diagnosis in the late 1980s and younger age being predictive of longer survival.

Discussion

Over the past 10 years, the impact of AIDS on social behavior and medical practice has been profound. The 1990s portend more major changes as the focus of the epidemic shifts to more economically disadvantaged minority populations and the medical response to AIDS shifts to early intervention. More and more, AIDS is a chronic disease for

Science and Education

which an early focus on primary prevention is now being supplemented by early intervention efforts (secondary prevention). Physicians in the 1990s will continue to find themselves challenged by AIDS and HIV, but that challenge will more than before be within the context of clinical care and the effective deployment of a preventive and therapeutic arsenal. **OSMA**

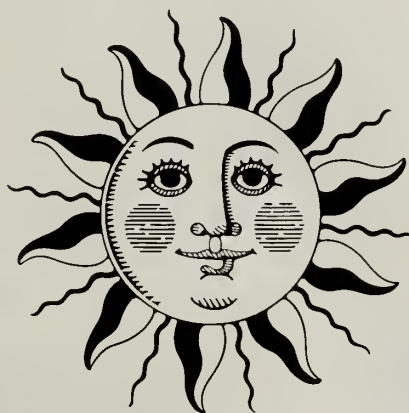
Cleveland ranks second in nation's immunization rate

Cleveland was recently cited by the Centers for Disease Control as one of the country's top cities in immunizing children against infectious diseases. According to a federal study, 79% of Cleveland children have completed the basic services of immunizations for measles, mumps, rubella, polio, diphtheria, whooping cough and tetanus by age 2. Stephen Hadler, MD, of the CDC, noted that the likelihood of an outbreak of such diseases was greatly reduced when there is an immunization rate of at least 75% and that, typically, immunization rates for cities are between 50%-60%.

Cleveland's success may be due, in part, to the fact that vaccines are available for all children — including those without health insurance — and that health professionals follow up the immunization records for children after enrollment in the public schools.

Pittsburgh ranked first in the measles study, which was conducted from 1980-1990 and which was based on public and

private school students' immunization records. Pittsburgh's immunization rate was 90%. Next came Cleveland, followed by Seattle, Boston, Houston, Philadelphia, the Bronx in New York and Jersey City in New Jersey. **OSMA**



FDA gets tough on sunscreen products

The FDA is toughening its rules on tanning oils and sunscreens. According to William E. Gilbertson, director of the FDA's over-the-counter drug division, the FDA wants products that offer no protection from the sun to carry warning labels about the health risk, reinforced this spring by a U.S. Environmental Protection Agency study, which linked rapid deterioration of the ozone layer to an increase in annual skin cancer deaths.

The agency also wants to ban as unnecessary sunblocks with sun protection factors over 30.

"The truth is, for any latitude in the United States, you don't need anything more than a 15," says Gilbertson. Bigger numbers,

up to 30, would be allowed for people in special situations, such as farmers and construction workers who spend a lot of time in the sun, and for those who travel or vacation in tropical zones.

In addition, the FDA proposal calls for banning, or at least discouraging infant sunblocks, because it believes such products encourage parents to put children in the sun, exposing them to a potential health risk. Sun-care company executives, however, say that a ban on baby blocks and tanning oils could discourage sunscreen use.

The FDA's sunscreen proposal was scheduled to be completed last month, and is expected to change before being adopted next year. **OSMA**

OMEN returns

It's back! The Ohio Medical Education Network (OMEN), an audio network within the Ohio State University Center for Continuing Medical Education, resumed programming last month after taking the summer off. Programs scheduled for this month and next include:

Oct. 7-11 — Sinusitis — Medical and Endosurgical Managements: A Primary Care Perspective

Oct. 4-18 — Stroke — Maximizing Patient Outcome: Early Recognition, Management and Rehabilitation

Oct. 21-25 — Peptic Ulcer Disease: New Frontiers

Oct. 28-Nov. 1 — Pacemakers: Indications and Management

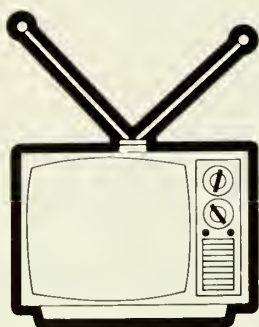
Nov. 4-8 — Vascular Disease: Office Evaluation, Medical and Surgical Management

Nov. 11-15 — The Diabetic Pregnancy

Science and Education

Nov. 18-22 — Melanomas — A National Epidemic: Prevention, Screening and Management

Any questions about the programs or the network can be answered by the Center for CME, (800) 492-4445. **OSMA**



Ohio research

- **Rotavirus vaccine studied**

A vaccine that will provide immunity against rotavirus, a potentially severe diarrheal disease, has been developed and is now being tested on infants in the Greater Cincinnati area. The vaccine was developed by the National Institutes of Health and has been in the test stages for two years. This national study involves nearly 1,000 infants and will include approximately 100 infants from selected pediatric practices in the Cincinnati area.

- **Desert Storm stresses measured**

Desert Storm proved to be a

short war, but it may have long-term effects on the men and women who fought it. A collaborative study between the Department of Family Medicine and Psychiatry at the University of Cincinnati's Medical Center will extend research started over a year ago on war-related stress. The UC study will attempt to gather more empirical evidence of the stresses of war and separation, with the goal of more effectively meeting the needs of service people, as well as their friends and family.

- **Safer blood supplies**

Light-sensitive photochemicals may be used in the future to rid the blood of harmful viruses, such

Camp designed for future docs

MEDCAMP, a three-day, live-in camp experience, designed to enhance student interest in medicine and the life sciences, took place recently at the Northeastern Ohio Universities College of Medicine (NEOUCOM). Approximately 40 "Beginning Doctors — BD's" participated in microbiology, physiology, anatomy, and physical diagnosis (medicine) laboratories, which illustrated aspects of a clinical case. The student groups developed and presented their findings at a grand rounds case presentation during the closing ceremony. The Martha Holden Jennings Foundation of Cleveland and the Sisler McFawn Trust of Akron funded the science outreach program. **OSMA**



Bones, joints, tissues, and muscles were the subject of the human anatomy laboratory at MEDCAMP. Working in the anatomy laboratory with some of the students were (l-r) Sandy Bauza, NEOUCOM graduate student; Laura D. Nohrden; Jodi Nicole Holtzman; Janice Spalding, MD, NEOUCOM assistant professor of Clinical Family Medicine; Shannon Neutzling; and Leah Campbell.

Science and Education

as HIV.

Kathleen Specht, an associate scientific director with the northwest Ohio region of the American Red Cross, is leading a research team at Bowling Green State University's Center for Photochemical Sciences on a project that could lead to new ways to ensure the safety of the nation's blood supply. Virology and hematology specialists from the Medical College of Ohio at Toledo are assisting her.

"The aim of the program," says Specht, "is to find a chemical that binds to these viruses and will inactivate the virus photochemically."

She will be looking at chemicals

that bind to viral nucleic acids and can be activated by red light.

About 10 research groups across the country are involved in similar projects, sparked by the concern of contracting AIDS through a tainted blood transfusion. The regional Red Cross is funding Specht's research.

• Ohio's research centers get boost

Ohio-based research may soon be on the upswing, thanks to an \$11.4 million loan, recently approved by the Ohio Board of Regents and designed to help Ohio's seven universities build better research centers. Among those receiving the interest-free

loans, which are to be paid back on a 10-year schedule, are: Ohio State University, \$2,550,000 for a biotechnology center; the University of Akron, \$212,500 for a nuclear magnetic resonance laboratory; Case Western Reserve University, \$2,200,000 for a macromolecular sciences building; and the University of Cincinnati, \$2,406,775 for hazardous waste research. **OSMA**



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For a conference brochure or more information, please contact The Ohio State University Center for Continuing Medical Education at (614) 292-4985 or 1-800-492-4445.

Next Month in OHIO Medicine

- Will lifting of cap on malpractice awards affect your premium?
- Survey reflects changing attitudes of young physicians
- Renewed interest in capital punishment bill as paddling incidents decrease
- Don't eat the fish: Lake waters stir new controversy

Obituaries

ALTON W. BEHM, MD, Chardon; Case Western Reserve University School of Medicine, 1935; age 83; died July 9, 1991; member OSMa and AMA.

RICHARD D. BUCHANAN, MD, Chevy Chase, MD; University of Cincinnati College of Medicine, 1979; age 40; died July 9, 1991; member OSMa.

PAULINE E. GERBER, MD, Hamilton; University of Kansas School of Medicine, Lawrence-Kansas City, KS, 1939; age 82; died July 18, 1991; member OSMa and AMA.

JOHN MCGREEVEY, SR., MD, Warren; University of Iowa College of Medicine, Iowa City, IA; 1944; age 71; died July 19, 1991; member OSMa and AMA.

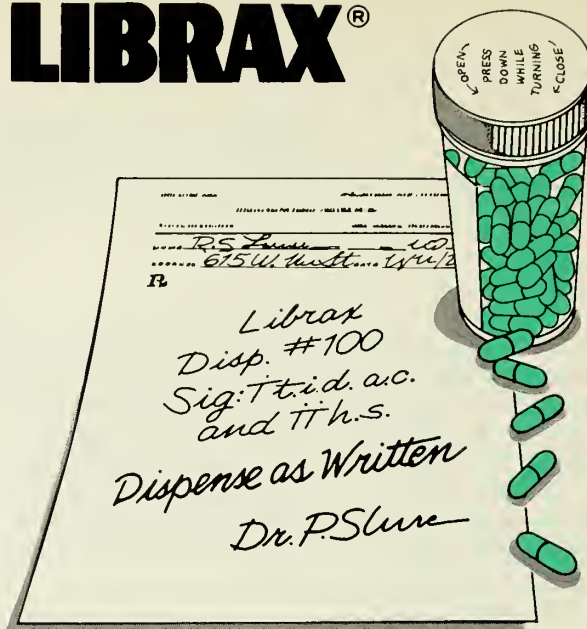
MARSHALL C. MORGAN, MD, Akron; Ohio State University College of Medicine, 1948; age 66; died July 29, 1991; member OSMa.

SAMUEL W. ROBINSON, MD, Columbus; University of Pennsylvania School of Medicine, Philadelphia, PA, 1941; age 75; died August 6, 1991; member OSMa and AMA.

JAMES F. SLOWEY, MD, Cleveland; St. Louis University School of Medicine, St. Louis, MO, 1923; age 94; died July 15, 1991; member OSMa and AMA.

ROBERT J. WEINRICH, MD, Massillon; Ohio State University College of Medicine, 1933; age 83; died July 23, 1991; member OSMa and AMA.

Specify Adjunctive
LIBRAX®



Each capsule contains 5 mg chlorthalidone HCl and 2.5 mg clidinium bromide.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlorthalidone HCl and/or clidinium Br.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Withdrawal symptoms: The barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlorthalidone HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlorthalidone HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

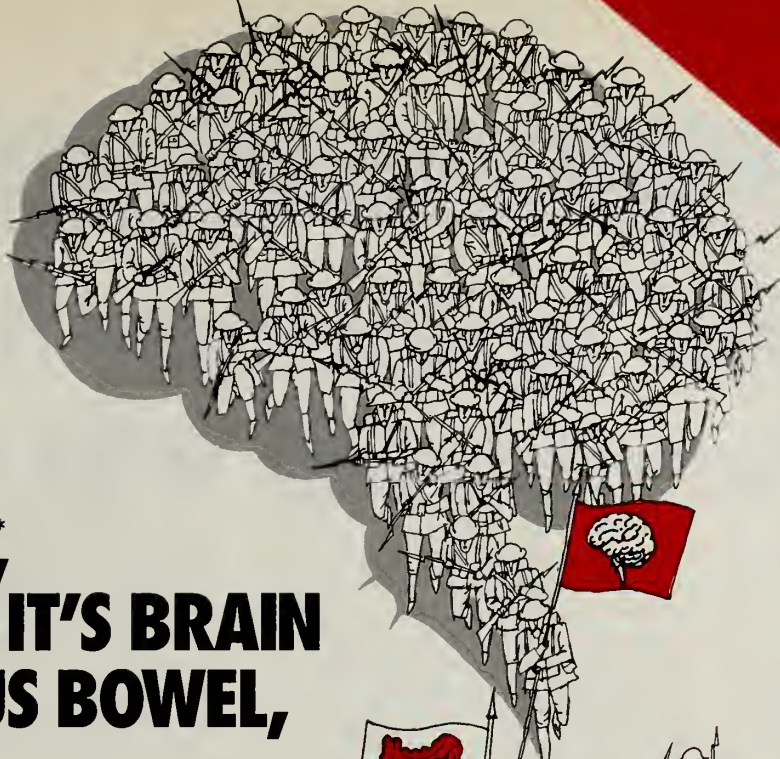
Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlorthalidone; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Revised: February 1988



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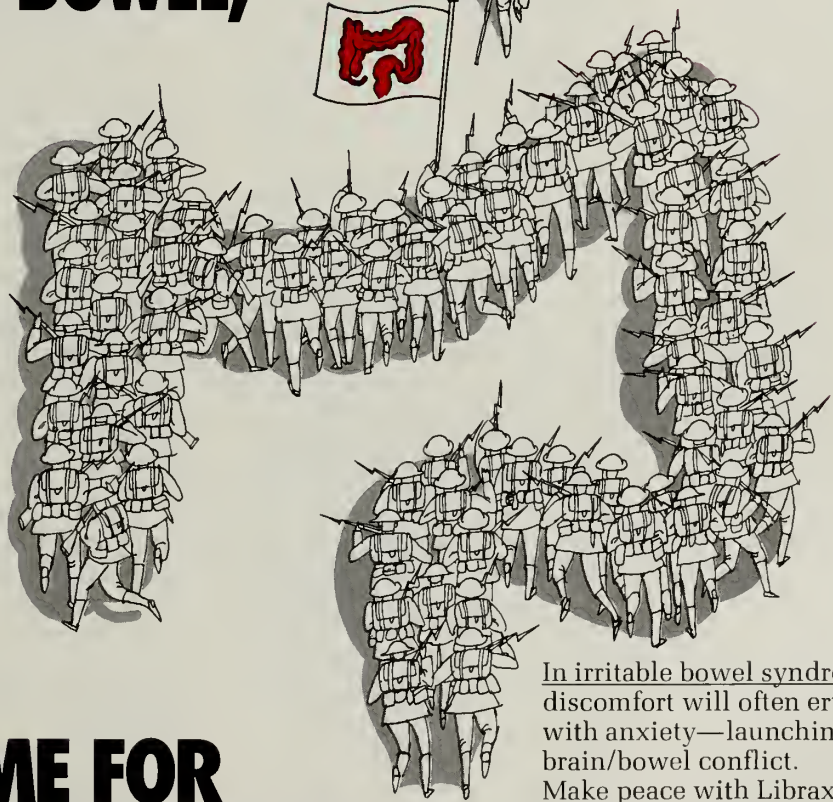


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Physician Responsibilities Under New Living Will Law

With the passage of Senate Bill 1, Ohio physicians are granted certain immunities for actions relating to patient living wills (declarations), durable powers of attorney for health care and consent by family members for patients with no advance directive. In order to qualify for these immunities, physicians must satisfy certain new procedural requirements set forth in the new statute. To the greatest extent possible, the legislation was drafted to codify existing practices in the physician community as they relate to honoring patient and family decisions on health care treatment. However, as some of the protocols may differ from current practices, physicians and health-care facilities should familiarize themselves with the following procedural requirements.

Durable Power of Attorney for Health Care — General

Under a durable power of attorney for health care, the power of an attorney in fact to make health care decisions on behalf of the principal (person executing the document) is not limited to situations where the principal is in a terminal condition or permanently unconscious state. At any time the principal lacks the capacity to make his or her own health-care decisions, even if only on a temporary basis, the right to direct treatment shifts to the attorney-in-fact. Accordingly, there are certain general requirements placed on physicians for all health-care decisions made pursuant to a durable power of attorney for health care, including those unrelated to life-sustaining treatment for a terminal or permanently unconscious patient.

There are essentially four general requirements to be satisfied by a physician prior to implementing a health-care decision made by an attorney-in-fact. Each of these necessitates a good faith effort by the physician in order to qualify for the

immunity from civil or criminal liability and professional disciplinary action.

The first provides that the attending physician believes the attorney-in-fact is authorized to make the health-care decision on behalf of the principal. This implies that the physician has been provided with evidence of the durable power of attorney for health care, has received some assurance that the person claiming to be the attorney-in-fact is actually the person so designated, determines the health-care decision in question is consistent with any specific terms in the document and not prohibited by law, and is not aware that either the document or the designation of attorney in fact under it have been revoked.

With regard to this latter, if an attending physician has been made aware of the existence of a durable power of attorney for health care, a revocation is not effective until it is communicated to the attending physician by the principal, a witness to the revocation, or by other health-care personnel to whom the revocation is communicated by a witness. If made aware of a revocation, the attending physician or someone acting at his or her direction is required to make the revocation a part of the patient's medical record. While there is no statutory requirement that the existence of a durable power of attorney for health care be made a part of the medical record, this would be an advisable practice and is consistent with the requirement that a revocation be recorded.

The second general requirement is that the attending physician determines to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, that the principal has lost the capacity to make informed health-care decisions for himself or herself. Note that this lack of capacity need not be judged to be permanent if the decision is not one

relating to life-sustaining treatment for a terminal or permanently unconscious patient.

The third requirement is that the attorney-in-fact be provided with sufficient information to satisfy the standard of informed consent, or refusal or withdrawal of informed consent, prior to making a health-care decision. The statute does not expressly require that this information be provided by the attending physician, however the general law of informed consent clearly holds the physician responsible for ensuring that the informed consent standard is satisfied.

The final general requirement for a physician seeking to implement the decision of an attorney-in-fact pursuant to a durable power of attorney for health care is that he or she believes that the decision is consistent with the desires of the patient. If the attorney-in-fact advises the physician that the patient's desires are unknown, and the physician believes that the patient's desires are unknown, the physician must further believe the decision is in the best interests of the patient.

Limitations on Decisions Under Durable Power of Attorney for Health Care

A physician dealing with a patient who has executed a durable power of attorney for health care must also be aware of the general limitations which the statute places on the types of decisions which can be made on behalf of an incapacitated patient. The first of these provides that life-sustaining treatment, and artificial nutrition and hydration may not be withheld or withdrawn from a patient unless he or she is in a terminal condition or a permanently unconscious state. Specific procedural requirements and physician responsibilities for such withholding or withdrawal are outlined below. The second limitation precludes a decision to withhold or withdraw

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treatments or procedures which are administered to provide comfort or alleviate pain and not for the purpose of postponing death.

With regard to pregnant patients, the statute restricts the refusal or withdrawal of informed consent to health care if the refusal or withdrawal would terminate the pregnancy. Such a decision may not be honored by a physician unless he or she determines that either the pregnancy or the health care proposed to be refused or withdrawn would pose a substantial risk to the life of the patient, or unless the attending physician and one other physician who has examined the patient determine to a reasonable degree of medical certainty and in accordance with reasonable medical standards that the fetus would not be born alive. While no express documentation requirement exists in the statute, if such determinations are made, they should be entered in the medical record.

The final statutory limitation on the nature of decisions which can be made by the attorney-in-fact, and thus honored by the attending physician involves health care to which the patient had previously consented. Informed consent to such health care may not be withdrawn unless one of the two following conditions is satisfied: a change in the physical condition of the patient has significantly decreased the benefit of the health care; or the health care is not, or is no longer, significantly effective in achieving the purposes for which the patient consented to its use. Again, although no documentation requirement exists, it would be prudent to enter such determinations, which would be made by the attending physician, in the patient's medical records.

In addition to these statutory limitations, the authority of an attorney in fact can be specifically limited by the person executing the

document. Physicians should look for any particular limitations included in a patient's durable power of attorney for health care to ensure that both he or she, and the attorney-in-fact, act consistently with the expressed desires of the patient.

Living Will — General

Ohio's new statute allows an individual to set forth, in advance, personal desires regarding the administration of life-sustaining treatment if he or she is diagnosed as being in a terminal condition or permanently unconscious state and unable to participate in treatment decisions. It differs from a durable power of attorney for health care as it communicates a decision already made by a patient rather than delegating that decision-making authority to another individual. Accordingly, a living will does not become operative until a patient has been diagnosed as being in a terminal condition or

Living will kits are available

Since the signing of the living will bill, Senate Bill 1, by Gov. George Voinovich in July, the OSMA Department of Communications has been busy preparing detailed information and preprinted forms for physicians and their patients on the specifics of the Ohio new living will law.

Carol Wright Mullinax, OSMA's Communications director, explains that OSMA has been working with the Ohio State Bar Association to develop a group of physician/lawyer teams to act as a speakers' bureau addressing the media and community groups on the implementation of the living will law. For these teams, a 10-minute video has been prepared for use in their presentation along with a speakers kit. The OSMA has called upon the county medical societies to help them with this endeavor.

The enactment of the living will bill that becomes law on October

10 means that Ohioans will, for the first time, be able to execute advance documents specifying their desires regarding the use of life-sustaining treatment if they are in a terminal condition or permanently unconscious state. The bill also establishes formal protocols for decisions by family members in situations where there is no living will or durable power of attorney for health care.

The OSMA Communications Department is developing a living will kit that will contain a living will form, a durable power of attorney for health care form, an explanation of how to fill it out and what should be done once the form is completed and signed. Patients with questions on completing the form are advised to consult their attorney. The living will kits will be distributed through a post office box for \$2 each. The post office box will be publicized through news releases to the media

and other interested parties.

Elsewhere in *OHIO Medicine* this month physicians will find a detailed article on the living will bill. An order form will accompany that article. Upon completion of the form, physicians will receive a reprint of the article in this month's *OHIO Medicine* plus a list of commonly asked questions/answers from patients, a poster to display in his/her office, plus a supply of brochures on the living will law. The brochures and poster will contain ordering information.

Members of OSMA may call the office at (800) 766-OSMA with any questions pertaining to the living will law. The OSMA Communications Department will not be able to respond to patients' questions. The department suggests that patients contact their attorney.

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permanently unconscious state and has been determined to have permanently lost the capacity to make informed decisions regarding life-sustaining treatment.

At the time a physician is made aware of a patient's living will, he or she must make the document a part of the patient's medical records. Similarly, if an attending physician is advised that a living will has been revoked, either by the patient, by a witness to the revocation, or by other health-care personnel to whom the fact of the revocation has been communicated, this fact must also be entered in the medical record.

Life-Sustaining Treatment Decisions Under a Living Will or Durable Power

Both a living will and a durable power of attorney for health care may be used as a means of ensuring that a terminal or permanently unconscious patient's desire to avoid unwanted medical treatment is honored by family and health-care providers. In either case, the first step toward effectuating a decision by an attorney-in-fact or as set forth in a declaration, to withhold or withdraw life sustaining treatment, is the diagnosis of a terminal condition or a permanently unconscious state.

By definition, the diagnosis of terminal condition and permanently unconscious state requires concurrence by two physicians who have examined the patient. For a diagnosis of terminal condition the attending physician must determine that the patient is in an "irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty and according to reasonable medical standards . . . both of the following apply: (1) there can be no recovery; (2) death is likely to occur within a relatively short time if life-sustaining treatment is not administered." The statute does not dictate the qualifications of a consulting physician for a diagnosis of terminal condition, other than that he or she be licensed or otherwise authorized to practice medicine or surgery or osteopathic medicine or surgery in the state of Ohio.

For a diagnosis of permanently unconscious state, the attending physician and a second physician must determine, to a reasonable degree of

medical certainty and in accordance with reasonable medical standards that the patient is both "irreversibly unaware of himself and his environment" and "there is a total loss of cerebral cortical functioning, resulting in the [patient] having no capacity to experience pain or suffering."

The second physician required for a diagnosis of permanently unconscious state must be one "who, by virtue of advanced education or training, of a practice limited to particular diseases, illnesses, injuries, therapies, or branches of medicine and surgery or osteopathic medicine and surgery, of certification as a specialist in a particular branch of medicine or surgery or osteopathic medicine and surgery, or of experiences acquired in the practice of medicine and surgery or osteopathic medicine and surgery" is qualified to make such a diagnosis which satisfies the above criteria. As with terminal condition, such consulting physician must be licensed or otherwise authorized to practice medicine or osteopathy in Ohio.

It should be noted that the law as it applies to living wills, provides that an individual can specify whether the document applies if he or she is in a terminal condition, permanently unconscious state, or both. Depending upon whether it is intended to apply in either or both situations, the document must use either or both terms and define them in a way substantially similar to the statutory definitions. A physician confronted by a patient with a declaration must therefore ensure that the document and its directive regarding life-sustaining treatment applies to the situation which has been diagnosed. If, for example, the living will is silent as to permanently unconscious state, the physician would be precluded from withholding or withdrawing life-sustaining treatment from a permanently unconscious patient.

The second condition that must be satisfied before the living will becomes effective, or an attorney-in-fact can make a decision regarding life-sustaining treatment, is a determination by the attending physician that the patient is no longer able to make informed decisions about the administration of life-sustaining treatment, and there is no reasonable possibility that the capacity to make

such decisions will be regained.

For a patient with a durable power of attorney for health care, who has been diagnosed as terminal or permanently unconscious and determined to have lost the capacity to make treatment decisions, the attending physician is required to attempt to determine the patient's desires, to the extent that the patient is able to convey them, regarding the use or continuation or withholding or withdrawal of life-sustaining treatment. A report of this attempt must be entered in the patient's medical records.

As a practical matter, since an attorney-in-fact can't ask that life-sustaining treatment be withheld or withdrawn from a patient unless he or she has permanently lost the capacity to make informed health-care decisions, the attending physician will likely not receive any meaningful insight even from a communicative patient. However, in the durable power of attorney document itself, the patient may have included a statement of his or her desires regarding life-sustaining treatment. If this is the case, the required notation by the attending physician in the patient record should reference the comments contained in the document.

Once a living will becomes operative, ie. both of the above determinations have been made (diagnosis of terminal condition or permanently unconscious state and determination of incapacity to make decisions regarding life-sustaining treatment), the attending physician must document both determinations in the medical record and ensure that the terms of the living will or a copy of the document are also included in the record.

Nutrition and Hydration — Living Will or Durable Power

The new law precludes the withholding or withdrawal of any procedure or treatment which is administered to provide comfort and alleviate pain, rather than to postpone death. This prohibition on ceasing treatment that constitutes comfort care will preclude the withholding or withdrawal of artificial nutrition or hydration, if, in a given situation, they are administered for purposes of providing comfort or alleviating pain rather than for the purpose of

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postponing death. If, on the other hand, artificial nutrition and hydration do not serve to provide comfort or alleviate pain but rather to impede the dying process, then, if certain procedural requirements are satisfied, they may be withheld or withdrawn pursuant to a durable power of attorney for health care or a living will.

In situations involving either a durable power or a living will, an attending physician must make three determinations prior to effectuating a decision to withhold or withdraw artificial nutrition or hydration. The first of these requires that the patient have been diagnosed as being in a terminal condition or permanently unconscious state following the procedural guidelines outlined above.

The second requirement is that the attending physician and at least one other physician who examines the patient must determine, to a reasonable degree of medical certainty and according to reasonable medical standards that artificial nutrition and hydration do not constitute comfort care in the given case, ie. that they do not, or no longer, serve to provide the patient with comfort or alleviate his or her pain. By certifying this, the attending physician and consulting physician are in essence saying that in the particular case at hand, artificial nutrition and hydration constitute life-sustaining treatment, which may be withheld or withdrawn according to the decision of an attorney-in-fact or the terms of a living will document, rather than comfort care.

The third issue that must be addressed by the attending physician applies only in situations where the diagnosis is one of permanently unconscious state. In these cases, the attending physician must be assured that the document itself expressly authorizes the withholding or withdrawal of artificial nutrition and hydration if the patient is in a permanently unconscious state. The statute clearly requires any individual executing a durable power of attorney for health care or a living will, who intends to authorize the withholding or withdrawal of artificial nutrition or hydration in these circumstances, to include an express authorization for the withholding or withdrawal of artificial nutrition and hydration if he or she is diagnosed as being in a

permanently unconscious state and two appropriate physicians determine that they do not serve to provide comfort or alleviate pain. Such statement is required to be in capital letters, separately signed or initialed by the person executing the document. Accordingly, the attending physician must verify that such a statement appears in either type of document prior to withholding or withdrawing artificial nutrition and hydration from a permanently unconscious patient.

Such express authorization is not required for a patient who is in a terminal condition. The only two prerequisites to withholding or withdrawing artificial nutrition or hydration from a terminal patient are the diagnosis, as described above, and the certification that they do not serve to provide comfort or alleviate pain. The attending physician should, however, verify the fact that either type of document does not expressly state a desire that artificial nutrition and hydration be continued regardless of the patient's diagnosis or physical state.

The attending physician should include in the medical record his or her determination that the provision of artificial nutrition and hydration do not provide the patient with comfort or alleviate his or her pain. The consulting physician should also enter his or her findings in the medical record.

Notification Requirements

After an attorney-in-fact has decided to use or continue or withhold or withdraw life-sustaining treatment, or after a living will has become operative, the attending physician may not immediately proceed to implement the decision. In both situations, the attending physician is required to provide notice of the intention to implement the decision to a designated individual or class of individuals.

In a situation involving a durable power of attorney for health care, the attending physician is required to make a good faith effort and use reasonable diligence to notify the highest priority individual from the following hierarchy:

- 1) Guardian, if any;
- 2) Spouse;
- 3) All adult children who are available within a reasonable period of time for consultation;

- 4) Parents;
- 5) An adult sibling or if there are more than one, a majority of those available within a reasonable period of time for consultation.

It is important to understand that all family members represented on the above list do not have to be notified by the attending physician. Notification must only be given to the person or persons in the highest priority class. For example, if the patient has a spouse, notice need only be provided to the spouse. If the patient has no spouse but has adult children, efforts need to be made to notify all the children who are reasonably available. The statute does not define "reasonably available" however it should be assumed that the fact that one child resides out of state would not render them unavailable for consultation. On the other hand, if an adult child's location is unknown, or is such that he or she cannot be reached, it is probably safe to rely on notice to the others who are available. Notation in the medical record should reflect the nature of the attempts made and the reason why they were unsuccessful. The names of those notified and the manner of notification are required to be entered in the medical record.

The notice requirement for a living will which has become operative is essentially the same. The one difference is that an individual executing a living will is allowed by law to designate in the document a person or persons to be notified at the time that his or her decision on life-sustaining treatment is to be implemented. If the document does not make such designation, the notice should go to the highest priority individual or class from the list above. Documentation requirements for a patient with a living will are identical to those for a durable power of attorney for health care.

Objections to the Decision

After the appropriate person or persons have been notified as described above, or once the attending physician has entered in the medical record his or her reasons for not providing the requisite notice, certain individuals have a period of 48 hours in which to notify the attending physician that he/she or they intend to file a complaint challenging the

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decision either to use or continue or withhold or withdraw life-sustaining treatment.

Where the decision is made by an attorney-in-fact pursuant to a durable power of attorney for health care, any person in the class that was notified or that was to receive notification (but despite good faith and reasonable diligence the attending physician was unable to notify them) may inform the physician within the 48-hour period of his or her intention to file a complaint in the probate court. In addition, the next class of the hierarchy in which the patient has family members may also indicate their intention to file a complaint. While this second class does not have to be notified, they do have the ability to legally challenge the decision. If the second applicable class consists of more than one member, a majority of the members have to join together to initiate the challenge; a single member of this class is precluded from acting unilaterally. This is a significant distinction since any member of the first priority class (ie. the class that receives the notice) may act alone to file a complaint challenging the decision.

The second class in a given situation may not be that class directly below the first priority class in the hierarchy. For example, if a patient had a spouse but no adult children, the spouse would receive the notice and could initiate a challenge and the patient's parents could also file a complaint. If the patient had no guardian or spouse but had parents and adult siblings, these two classes could challenge the decision. Again, in order for the adult siblings to challenge, because they are only the second priority class, a majority of the siblings would have to join together in filing the complaint.

In a situation involving a living will, those who can appeal the implementation of the decision contained in the living will document will depend on whether the patient has designated someone to receive the notice. Any person notified by the attending physician (or who would have been notified if the physician would have been able to do so using reasonable diligence) can advise of an intention to challenge within the 48-hour period. If the document specifies a person or persons to receive the notice, any or all of these individuals may indicate an intention

to file a complaint. If the document did not so specify, anyone in the first priority class may challenge the decision.

If the living will specifies to whom the notice should go, the two highest priority classes which are applicable to the patient are also eligible to file a complaint. If either or both of these two classes contain only one person, that person may challenge. If either or both classes contain more than one person, a complaint can be filed only if joined in by a majority of the class members. Again, the highest two priority classes need not be successive in the hierarchy list. If a patient has neither a guardian, spouse, or surviving parents (numbers 1, 2, and 4 on the above list) the two priority classes would be adult children and adult siblings (numbers 3 and 5 on the list).

If a living will document does not specify to whom notice should be given, the attending physician will have notified or attempted to notify the person or persons in the first priority class. Accordingly, in this case, the right to challenge the decision extends only to the next applicable class. However, any individual in the first priority class may initiate the appeal (since they were to receive the notice absent specification in the document) while a majority of the second class would be required.

It is important to remember that the attending physician need only attempt to notify the first priority class or the person(s) designated in a living will. While limited others have the opportunity to challenge the decision they are not required to be notified. While this is less onerous on the attending physician, as a practical matter, the ability of some family members who have not received the notice to object to the proposed course of action requires that the physician either wait the full 48 hours after notice has been given, or attempt to contact all those family members who would be eligible to appeal based on the criteria outlined above. It must also be remembered that those who are eligible to appeal must indicate their intention to do so to the attending physician within 48 hours after the requisite notice was given, whether or not the person seeking to appeal was one who received the notice. In other words, a family member eligible to appeal but not one required to receive

the notice, does not have 48 hours from the time that he or she learns of the decision regarding life-sustaining treatment but may only act within 48 hours after the notice has been received by the appropriate individual or class.

Complaint Procedure

If the attending physician is advised within the 48-hour time period that an individual who, or class that, is eligible to challenge the decision of an attorney in fact or a living will, intends to file a complaint, no further action toward implementing a decision to withhold or withdraw life-sustaining treatment may be taken. If the decision which is being challenged is a decision to continue life-sustaining treatment, and the challenge seeks to allow such treatment to be withheld or withdrawn, obviously the treatment must be continued pending the outcome of the legal proceeding.

Not only are the individuals who are eligible to file a complaint limited as discussed above, but a complaint can be filed on a limited number of grounds. The factual grounds on which a decision can be challenged are as follows:

- 1) the determination that the patient has lost the capacity to make decisions himself or herself is inaccurate;
- 2) the patient may have lost decision-making capacity temporarily but there is a reasonable possibility that he or she will regain such capacity;
- 3) the diagnosis of terminal condition or permanently unconscious state is incorrect;
- 4) the proposed course of action is not authorized by the document or is prohibited by law;
- 5) the document does not satisfy the statutory technical requirements or has expired;
- 6) the document was executed when the patient was not of sound mind or was under or subject to duress, fraud, or undue influence;
- 7) the attorney-in-fact is not acting consistently with the desires of the patient, or if unknown, in his or her best interests (durable power only).

These are the sole grounds on which a complaint can be filed. In addition, the state and other interested parties are precluded from either initiating or joining in an action to challenge the

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decision.

A complaint must be filed with the probate court within two business days after notice of intention to object is provided to the attending physician. An expedited procedure to determine the merit of the objection is required by the probate court. Once such a procedure has been commenced, the attending physician should maintain the patient on life-sustaining treatment pending the outcome of the appeal. The probate court, based on expert testimony from other physicians given on behalf of the person challenging the decision, may order the attending physician to re-evaluate his or her medical evaluations of the patient's decision-making capacity as well as the diagnosis of terminal condition or permanently unconscious state. If such an order is rendered, the attending physician must review his or her determinations and if, after doing so, those determinations remain unchanged, the probate court must be advised in writing. The attending physician must then comply with the transfer provisions discussed below.

Patient's With No Advance Directive

The new law also establishes protocols for physicians dealing with patients who are in a terminal condition or permanently unconscious state, but who have executed neither a living will nor a durable power of attorney for health care. For a terminal patient, written consent to the withholding or withdrawal of life-sustaining treatment may be given by the appropriate individual or individuals from the hierarchy set forth below. Such consent must be witnessed by two individuals who are not related to the patient by blood, marriage, or adoption, and who are neither the attending physician nor the administrator of a nursing home in which the patient is receiving care.

For a terminal patient, the attending physician must first verify that the patient has neither an effective living will or durable power of attorney for health care. He or she must then make the same determinations regarding lack of capacity to make health-care decisions and terminal condition as are required for patients who have a living will or durable power of attorney for health care. A second physician who has examined the patient must concur in the diagnosis of terminal condition.

In addition, if consent is sought for the withholding or withdrawal of artificial nutrition or hydration, the attending physician and a second physician must certify that artificial nutrition and hydration do not provide the patient with comfort or alleviate pain. Once these prerequisites are established, the attending physician can seek consent from the appropriate parties.

For a permanently unconscious patient, the requirements regarding determination of lack of capacity and diagnosis are the same as for patients with a living will or durable power of attorney for health care. However, consent to the withholding or withdrawal of life-sustaining treatment for a permanently unconscious patient may only be sought after the patient has been in such a condition for at least 12 months. Such consent is limited to life-sustaining treatment other than artificial nutrition and hydration, for which a separate procedure must be followed.

Consent may be given by the appropriate individual or individuals only after the attending physician has provided sufficient information to satisfy the requirements of informed consent. The consent must be given voluntarily and those giving it must be of sound mind.

The appropriate individual or individuals to give consent are those highest in priority from the following hierarchy:

- 1) Guardian;
- 2) Spouse;
- 3) An adult child, or if there are more than one adult children, a majority of those available for consultation within a reasonable period;
- 4) Parents;
- 5) An adult sibling, or if there is more than one adult sibling, a majority of those available for consultation within a reasonable period;
- 6) The nearest adult relative not in one of the above categories who is available for consultation within a reasonable period.

With regard to adult children, the law requires that the attending physician make a good faith effort and use reasonable diligence to contact all of a patient's adult children who are reasonably available, for purposes of obtaining consent. As was discussed in the context of the notice requirement

for patients with a living will or durable power of attorney for health care, the fact that an adult child is not present at a patient's bedside will not excuse the attending physician from making certain efforts to contact him or her. For a patient who has no advance directive, the obligation on the physician to contact all adult children when seeking consent to withhold or withdraw life-sustaining treatment may be even greater than the obligation to provide notice when the patient's decision, or that of his or her attorney-in-fact, is sought to be carried out. The medical record should clearly document the efforts made by the attending physician to contact adult children (and any other members of the highest priority class) and, if contact is not possible, should indicate the reasons.

If an appropriate individual or class is not available within a reasonable period of time, is not competent to give consent, or declines to decide, the attending physician may contact the next highest priority class in which the patient has relatives. However if the highest priority class is equally divided on whether or not to consent to the withholding or withdrawal of life-sustaining treatment, no consent can be given.

Consent on behalf of a patient with no advance directive must be given in good faith and must be consistent with any previously expressed desires of the patient. If the patient had not previously expressed his or her desires regarding the administration of life-sustaining treatment, the consent must be consistent with the type of decision the patient would have made, based on his or her lifestyle, character, and any other pertinent evidence. Absent actual knowledge of a previously expressed intention, or actual knowledge that a patient would have made a different decision, the attending physician is entitled to rely on a consent given by the appropriate party or parties.

Within 48 hours after consent is given by the priority individual or class, any individual in the first five classes of the hierarchy may notify the attending physician of his or her intent to challenge the decision in the probate court. Note that the right to challenge is limited to guardian, spouse, parents, adult children and adult siblings. Although a consent may be given by a more distant relative if

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Medical Board Notes

This new column in the legal section will relate activities of the Ohio State Medical Board, the state's licensing and disciplining agency for physicians. It is prepared with the assistance of Katrina English, JD, OSMA's associate legal counsel.

New "snitch" rules adopted . . .

New rules, codifying the state's already existing mandatory reporting requirements, were adopted in August and became effective September 1, 1991.

"Little has been changed in codifying these new rules," says Katrina English, JD, OSMA's associate legal counsel. "What they do is raise visibility of mandatory reporting and assist the medical board in enforcing the rules." One item that will continue to stay the same, for example, is the rule that says a doctor who has reason to believe a colleague may be incompetent must report that colleague not only to the hospital peer review committee, but also to the medical board. "There is some confusion on this issue," English says. Physicians often assume that once the colleague is reported to the hospital's peer review committee, the committee will make the necessary report to the board. "However, the reporting physician must notify both," says English. At the same time, however, any information that stems from a peer review process does *not* have to be reported to the board by members of the reviewing committee, as that information is considered confidential and is protected by law. Final actions taken, passed on peer review, are reportable, however.

Now, in addition to peer reviewers' confidentiality remaining

intact, is a new rule that grants limited anonymity to physicians who report their peers to the board. Prior to the new "snitch" rules, physicians could not make anonymous reports of wrongdoing. Under the new rules, however, the accuser will not be identified unless the investigation progresses beyond a certain point. The anonymity provision is included as additional insurance that the identity of the reporting physician will not be inadvertently disclosed and provides additional insulation from potential liability. So far, no physician has ever been charged with violating the mandatory reporting rules, and English believes the new rules will be more enforceable. "The board now has a clear-cut mechanism for enforcement," she says.

A summary of Mandatory Reporting Rules, drafted by the Ohio State Medical Board, is available through OSMA's Department of Legal Services. Write: OSMA, Dept. of Legal Services, 1500 Lake Shore Drive, Columbus, OH 43204-3824. Or call (800) 766-OSMA.

Prescribing for chronic pain . . .

The medical board has recently investigated several family physicians in the Lima area who regularly prescribe controlled substances for patients with chronic pain. One Lima physician was found by the board to be inappropriately prescribing these substances. The board issued a two-year probation for failure to adequately keep records pertaining to specific patients. The board then required him to complete 25 hours of CME during each of the two years in appropriate record-keeping courses. "Board members took the position that the substances prescribed by this physician may have been excessive

and his records were not complete," says English.

The board's Controlled Substance Committee is now looking at the issue of chronic pain management and is currently gathering information on the subject. Last month, physicians met with the board to discuss chronic pain management from the primary care perspective. This month, representatives from chronic pain management centers will address the subject. "The board is looking at either adopting a position paper with guidelines on appropriate levels, or a full-blown set of rules on this issue," says English. "Medical Board Notes" will keep you posted when and if either occurs.

Impairment rules drafted . . .

Members of OSMA's Physician Effectiveness Program Committee (PEP) as well as legal counsel have been working closely with the board to negotiate a fair set of rules for "the government of impaired practitioners and treatment providers." Like the Mandatory Reporting Rules, the drafting of new impairment rules does little beyond formalizing the status quo. However, at least one new twist has been added.

For example, under the new rules, physicians who have reported an impaired colleague now have the responsibility of periodically checking on that colleague's progress and reporting to the board any relapse that might occur. The OSMA differed with the board on the definition of a relapse, as well as on several other points, such as what items to include in a consent agreement. "We've worked out friendly compromises," says English. Questions regarding the new impairment rules should be addressed to the Department of

Legal

Legal Services (see first item for address and phone number).

Prescribing controlled substances to yourself and family . . .

Although a position paper was drafted this summer recommending against physicians prescribing controlled substances for themselves and their families, the matter was tabled at the OSMA's request until it could have time to study the paper and comment appropriately. The board then solicited comments from other professional associations, with discussion scheduled for the September meeting. By the time you read this, the paper will most likely have been adopted. The board's initial recommendation was that physicians not engage in this practice. Questions should be addressed to the Department of Legal Services.

Disciplinary guidelines standardized . . .

In an effort to keep discipline more uniform, the board revised guidelines that set "high and low" discipline measures for initial offenses. Says English: "Many of the guidelines go from 'revocation' for a high to 'reprimand' for a low, which covers the entire spectrum of potential actions. The board agreed to accept comments from interested associations, and the OSMA reviewed the guidelines and provided comment.

Patient bill of rights . . . The medical board is waiting for the AMA's permission to use its "Fundamental Elements of the Patient-Physician Relationship," which, when given, will allow the board to present the document as a Bill of Rights for Ohio patients. "It will probably be adopted before the end of the year," says English.

Put it in writing . . . All requests for confirmation of a physician's Ohio license status must now be made *in writing*. Mail your written requests to: The Ohio State Medical Board, 77 South High Street, 17th floor, Columbus, Ohio 43215. OSMA

OSMA opposes "Caller ID"

This month, the Public Utilities Commission of Ohio is expected to rule on whether or not Ohio Bell will be allowed to introduce its "Caller ID" service into the state.

Caller ID would allow consumers to instantly identify the phone number from which a call is made by flashing it on a display screen that would be attached to the subscriber's phone for a price of between \$60-\$80. In addition, customers with the Caller ID service would be charged an additional \$9 a month.

The OSMA was one of numerous organizations, including law enforcement and domestic violence agencies, that testified recently at public hearings held by PUCO across the state against the new service.

"We have concerns about the Caller ID service, and we object to it without a corresponding requirement that Ohio Bell offer its customers a call-blocking option at no additional costs," says J. Scott Clapp, JD, OSMA associate staff counsel.

Clapp explains that the Caller ID service could be blocked in two ways — per line and per call. Per line blocking would allow customers to keep certain phone numbers from appearing on Caller

ID screens — personal lines or home phones, for example. Per call blocking would allow customers to dial a phone number, then enter a special code that would keep that number from being identified to a particular party. Without the code, the line would identify the caller.

"We'd like to see Ohio Bell offer both options, at no cost to their subscribers," says Clapp.

Without the ability to block Caller ID, however, the OSMA joins other state medical associations, such as Florida, that believe the service could prove detrimental to both physicians and their patients.

Below are a few of the OSMA's concerns that Clapp expressed in testimony before the PUCO this August:

Breach of physician-patient confidentiality — Physicians have both a legal and ethical obligation to maintain confidentiality regarding their relationship to patients. However, if a physician places a call to a patient, either at his or her home or workplace, a spouse, dependent, supervisor, co-worker or others could obtain the identity of the caller simply by calling back the number. "We feel this could have a substantial impact on the right-to-privacy issue," says Clapp. He adds this could dramatically affect patients who must maintain contact with psychiatrists, addiction specialists, infectious disease or AIDS clinics. "You'd probably have a number of people who would never call for the results of an AIDS test," Clapp says.

Physicians right to privacy — Physicians have the right not to have certain phone numbers identified to callers. As one group of psychiatrists in North Carolina explained, night calls in their practice are handled from the

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Tissot's Twist in Taste

By James G. Ravin, MD

The taste of the public is notorious for being fickle. Consider the case of Tissot. He achieved great success early in his career as a fashionable painter of portraits in Paris and later in London, was invited by Degas to participate in the Impressionists' exhibitions, and capped his career with an enormously popular series of illustrations of Biblical themes.

Not long after his death in 1902, popular taste shifted and opinion of his art fell nearly to oblivion, only to rise again a few decades later. Several retrospectives of his work held during the past three decades, along with another twist in taste, have helped change opinion of his merit and caused prices for his work to skyrocket again. But the works most admired during his lifetime (religious paintings) are today considered trivial and boring, while those considered pedantic and monotonous when he was alive (portraits) are avidly sought today.

James-Jacques-Joseph Tissot made his debut at the Paris Salon in 1859, in his 23rd year, with five paintings. He was a realist, very representational in his work, and used photographs as compositional aids. He quickly became a very fashionable and worldly painter, wealthy as a young man. The

Franco-Prussian War caused an upheaval in Paris in 1870. Tissot was a sharpshooter during the Siege of Paris, but in the political turmoil that followed, he left France for London, where he remained for 11 years. There Tissot developed a romantic liaison with a beautiful divorcee, Kathleen Newton. Married at age 16 to a surgeon in the Indian Civil Service named Isaac Newton, she confessed to a close relationship with another officer, and had a child by him. She returned to England, had another child by an unnamed father, and with the two children moved into Tissot's home. By this time Tissot was a highly successful portrait painter in London, and was acquainted with important people in fashionable society. Curiously, Tissot illustrated the de Goncourts' novel *Reneé Mauperin*, in which the heroine died of consumption. At age 28 Kathleen Newton died of consumption in Tissot's home. Five days later Tissot returned to Paris, giving up his London career.

He turned to Spiritualism. One medium was able to materialize Kathleen Newton to his satisfaction, and he drew the apparition. While sketching in St. Sulpice church a service inspired him with a vision. This led him to travel to the Middle East to illustrate the Old and New Testaments. The newspapers followed the situation closely. He

prepared by a thorough reading of the Scriptures, the Talmud, the Jewish history of Flavius Josephus, the Apocrypha, and modern theologians and archaeologists. All this preparation resulted in two extremely popular series of Biblical illustrations. The filmmaker D.D. Griffith based his Biblical settings and costumes on Tissot's works. Even the recent movie *Raiders of the Lost Ark* used Tissot's art as the model for the lost Ark of the Covenant.

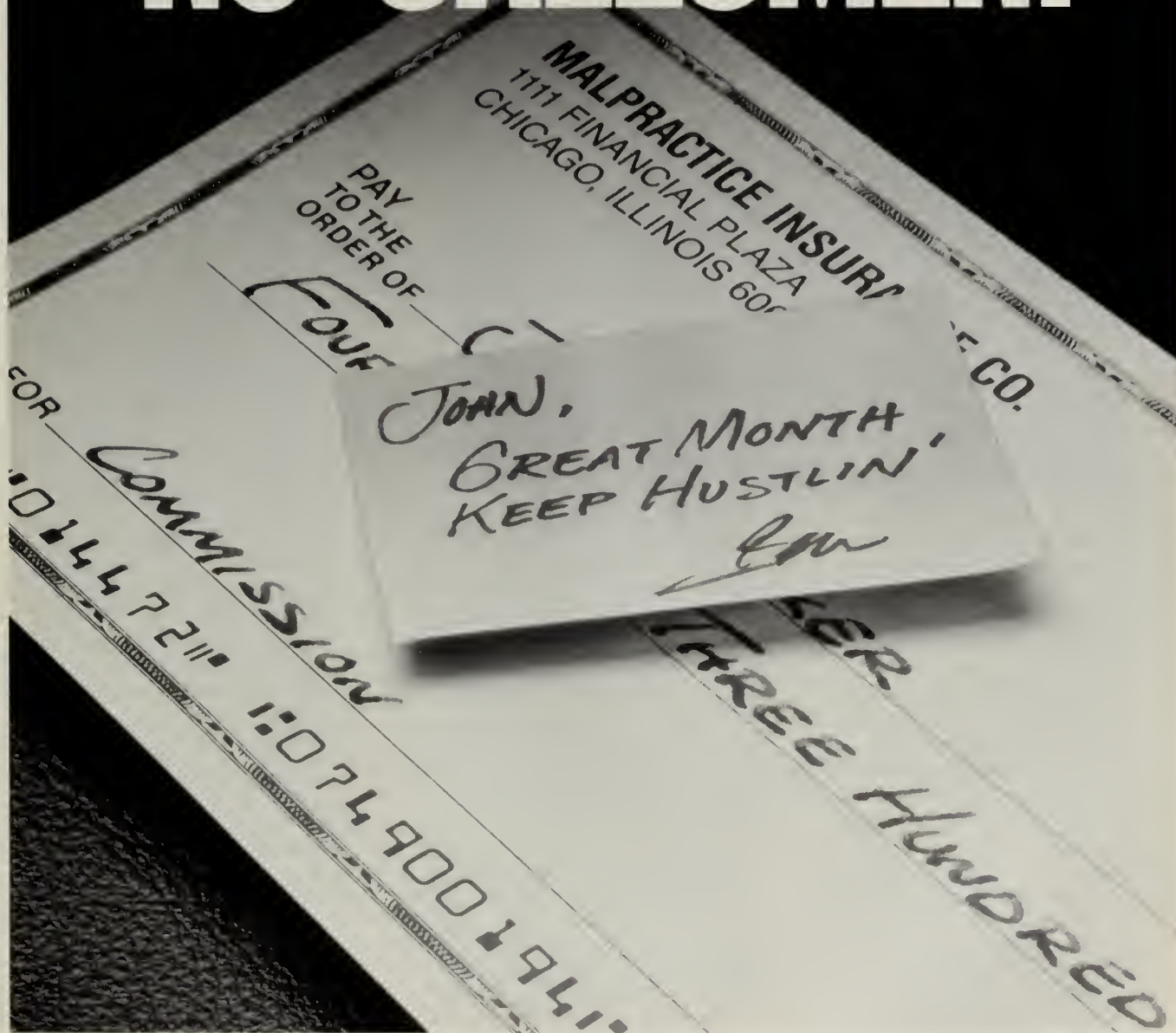
The Toledo Museum of Art owns an important Tissot painting, *London Visitors*. While certainly not a religious work, it depicts tourists on the steps of the National Gallery in London. St. Martin's-in-the-Fields may be seen in the background. Two young boys are dressed in the attire of Christ's Hospital. A cigar is humorously placed on the steps.

This painting, done mainly in shades of gray, lacks the brilliant colors of many of Tissot's works, but captures the colors typical of London. The unusual vantage point is usually attributed to the Japanese influence common in art of the time.

Tissot was friendly with many 19th century artists and authors, including Whistler, Manet, Degas, and Daudet. He and Degas created portraits of each other, and Degas invited Tissot to exhibit with the Impressionists. Knowing the vast

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and preventing problems for their clients. Their success isn't measured by how well they sell. But by how well they serve. For a different approach to professional liability, call your Medical Protective general agent today.

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Reimbursement

OMGMA meets with BWC to address problems

In an effort to iron out various claims processing complaints two Bureau of Workers' Compensation officials met with Mitch Wheeler, president of the Ohio Medical Group Management Association (OMGMA), and the OSMA Ombudsman office recently.

A list of 10 major concerns were discussed. They included:

1. Lack of reimbursement, by individual claim or prospectively.
2. Denial of claims when reporting more than one injection or other services, such as physical therapy, orthotics, etc.
3. The inability to obtain from BWC or self-insured accounts the current approved case number and/or approved condition.
4. Continued declarations by BWC that patient accounts are overpaid, without any resource from BWC, which denotes which patient accounts are involved.
5. Denial of claims pending by BWC because date of service is over two years old.
6. Reimbursement checks sent directly to individual physicians who actually are associated in group practice where checks should be sent.
7. The inability to obtain authorization for patient treatment services.
8. The unavailability of BWC staff to assist with physician questions.
9. Instances where patients have received direct payment for physician services.
10. Fees have been cut by UCR, effective April 1 and administrative costs to deal with BWC increased, i.e. refiles, inquiries, lack of

payment, etc.

The BWC officials agreed to evaluate the situation and see if they can resolve a few of these issues in the next six months. BWC officials agreed to consider eliminating the need for exact diagnosis reporting for certain specialties, such as radiology. They also agreed that establishment of a provider relations section to handle physician inquiries is appropriate. And, thirdly, they will evaluate the ICD to determine if diagnosis for industrial injuries could be identified in a range of acceptable diagnoses, and thus eliminate the exact match requirements.

At another meeting that month, the OSMA Committee on Workers' Compensation considered a proposal from BWC that became effective September 15 that suspended claims that exceed \$8,000 in bill charges to be paid in a lump sum reimbursed by BWC at 100% of the bill charged, with the settlement mechanism to follow later. The committee believed the concept was worth pursuing.

This is just the beginning. Additional meetings to discuss the concerns of physicians will follow in the next few months. *OHIO Medicine* will report any other changes in upcoming issues. **OSMA**

Medicare reaches out with new phone system

Now, thanks to the Audio Response Unit (ARU), Ohio and West Virginia providers can reach out and touch someone at Medicare. This telephone inquiry response system enables individuals to receive routine Medicare Part B information without operator assistance. Don't worry, phone representatives will still be available to assist with questions and

concerns.

The system may be accessed by calling: (614) 464-9924 or (614) 464-9925.

With a touch tone phone you can call the ARU to:

- Receive on-line detailed information on assigned claims:
 - Amount applied to the deductible
 - Amount paid on a claim
 - Adjusted payment information
 - Line item information
 - Claim denial information
 - Claim pending information
- Request pricing data for a specific procedure
- Order various reports:
 - Copies of previously issued Explanation of Medicare Benefits (EOMB) statements
 - Your Medicare-approved profile amounts (per procedure code)
 - Your Medicare-approved limiting charge amounts (per procedure code)
- Obtain the latest information on Medicare issues

The ARU will be providing ongoing instructions to help with questions with the new system. Once you become familiar with the ARU, you will be able to key ahead and move right to your selection without listening to all the menu items.

It is advised that before calling the Medicare ARU number that the provider have the following information readily available:

- Your Medicare Provider Identification Number (PIN)
- Your patient's Medicare number (for claim status and copies of previously issued EOMBs)
- Date of service (when requesting claim status)

Although it might take some time getting used to, the new expanded service should speed up getting the information you need at your fingertips. **OSMA**

Living Will guidelines . . . continued

there are no others reasonably available, competent, and willing to decide, a challenge is limited to closer family members.

As in situations where there is an advance directive, an objection to consent is restricted to certain factual bases. A consent, whether to continue life-sustaining treatment or to withhold or withdraw it, may be reversed by the probate court only if the party challenging it proves one of the following:

- 1) The patient is able to make his or her own decisions regarding the administration of life-sustaining treatment;
- 2) The patient has an effective living will or durable power of attorney for health care which would govern decisions regarding the administration of life-sustaining treatment;
- 3) The decision is not consistent with the patient's previously expressed intentions;
- 4) The decision is not consistent with what the patient would have wanted;
- 5) The person(s) giving consent did not have information sufficient to satisfy the requirements of informed consent;
- 6) The person(s) giving consent were not of sound mind or did not act voluntarily;
- 7) If the decision was made by a majority of the patient's adult children, the attending physician did not make a good faith effort and use reasonable diligence to notify all the adult children who were available within a reasonable period of time;
- 8) The decision-making process did not comply with the procedural requirements of the law;
- 9) The patient is not in a terminal condition or has not been in a permanently unconscious state for at least 12 months (this is a ground for appeal only if the decision being challenged is to withhold or withdraw life-sustaining treatment; not if the decision is one to continue such treatment).

Aside from allowing an appeal to be made by any of the close family members, the procedures for filing a complaint and review by the probate



Living will signing

Gov. George V. Voinovich signed the living will bill into state law July 9. The enactment of Senate Bill 1 marked the end of a struggle spanning more than a decade. The OSMA joined with the Ohio State Bar Association this legislative session, bringing doctors together with lawyers in support of the bill. Witnessing the signing are: (standing from right to left) Rep. Marc Guthrie, Newark; Rep. Richard Finan, Cincinnati; Rep. Neal Zimmers, Jr., Dayton; and Rep. Robert Nettle, Barberton. Seated are, Rep. Robert Hickey, Dayton; House sponsor, Gov. Voinovich; and Rep. Betty Montgomery, Perrysburg.

court are identical to that for situations involving an advance directive. Again, once the consent is given, the attending physician should wait 48 hours to see whether an eligible family member plans to challenge the decision. If he or she is advised that a complaint will be filed, any further action to withhold or withdraw life-sustaining treatment should await the outcome of the appeal.

Nutrition and Hydration — Permanently Unconscious Patient

If the above procedures are followed, consent may be given on behalf of a permanently unconscious patient to withhold or withdraw all forms of life-sustaining treatment other than artificial nutrition or hydration. In order to withhold or withdraw artificial nutrition or hydration from a permanently unconscious patient who has no advance directive, an additional step is needed.

After satisfying the above requirements, specific written consent, from the appropriate individual(s), must be obtained for the withholding or withdrawal of artificial nutrition or hydration. The attending physician and a qualified consulting physician must also certify that artificial nutrition and hydration do not provide the patient with comfort or alleviate pain.

Once these additional requirements are met, application must be made to the probate court for approval of the consent, and for an order to withhold or withdraw artificial nutrition or hydration. At the hearing on the application, any individual in the first five classes of the hierarchy may testify and present evidence related to the decision. In addition to verifying the factual prerequisites (ie. adequacy of diagnosis, patient unable to make his or her own decisions, artificial nutrition or hydration do not provide comfort or alleviate pain), and the legality of the procedure used to

Living Will guidelines . . . continued

obtain the consent, the probate court must determine whether the decision is consistent with the patient's previously expressed intent, or is what the patient would have wanted based on his or her lifestyle, character and other relevant evidence.

As in other probate court actions relating to the administration of life-sustaining treatment to a terminal or permanently unconscious patient, the state and other interested parties are precluded from participating in an action seeking consent to withhold or withdraw artificial nutrition or hydration from a permanently unconscious patient.

Miscellaneous Provisions

Pregnant Patients

If a pregnant patient is diagnosed as being in a terminal condition or permanently unconscious state, there

are certain restrictions on the withholding or withdrawal of life-sustaining treatment. Before giving effect to the terms of a living will or consent by an attorney-in-fact or other appropriate individual(s), the attending physician must make an additional assessment. If the withholding or withdrawal of life-sustaining treatment would terminate the pregnancy, the attending physician and a second physician who has examined the patient must determine, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, that the fetus would not be born alive even if the treatment was used or continued. Documentation to this effect must be included in the medical record.

Emergency Situations

The new law recognizes that emergency situations will occur during

which it is not possible to follow the protocols detailed above. Accordingly, the statute states that it should not be construed as affecting or limiting the authority of a physician or health-care facility to provide or not provide life-sustaining treatment to a person in accordance with reasonable medical standards applicable in emergency situations. It is important to note that the right to proceed with decisions regarding the administration of life-sustaining treatment in an emergency situation without adhering with the statutory procedures is limited to physicians and health-care facilities. There is nothing in the new law which authorizes non-physician emergency personnel to implement decisions regarding life-sustaining treatment whether by an attorney-in-fact, family member, or pursuant to a living will document.

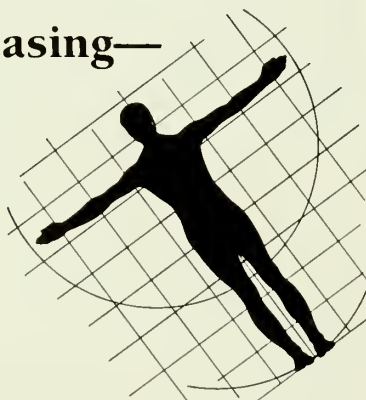
Transfer Requirements

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Caller ID . . . continued

doctors' homes by rotation. If the patient was able to learn one caller's phone number, "that doctor would be on call *every* night," they pointed out.

Right to an unlisted phone number — Ohio Bell has filed an application that would allow permanent modification or exemption from the code that allows consumers to maintain unpublished phone numbers. With the Caller ID system, unpublished phone numbers would not be exempt from the service. "What would be the point of having an unlisted number?" asks Clapp. "And why would Ohio Bell continue to charge for the service?"

Anonymous phone calls — Hotlines that deal with confidential medical issues (such as AIDS, addiction and suicide) would most likely be jeopardized if

the caller could not assume anonymity. In addition, OSMA believes a lack of anonymity could also have a negative impact on those who would report substandard medical care to county or state medical associations or to the Ohio State Medical Board.

Says Clapp: "We believe other services, like Call Tracing, would be just as effective in handling the problem of harassing telephone calls" — the primary purpose of the Caller ID system.

Other groups that have testified against the system include: the North Central Mental Health Center, Ohio Consumers' Council, the American Civil Liberties Union, the Ohio Association of Police Chiefs, the Fraternal Order of Police of Ohio and the Ohio Domestic Violence Network. **OSMA.**

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Tissot . . . continued

differences in their styles, and desiring to remain with that aspect of the public that preferred Salon pieces, Tissot refused. He created a fascinating body of work. His paintings have been considered merely highly finished period pieces done with considerable skill, but I believe Tissot went beyond that level, mastering the medium of oil painting. **OSMA**

References

Wentworth, MJ: *James Tissot, Catalogue Raisonne of his Prints*. Minneapolis Institute of Arts, 1978.

James Tissot 1836-1902. Exhibition Catalogue. London, Manchester and Paris, 1985.

J. *James Tissot, Biblical Paintings*. Exhibition Catalogue. Jewish Museum, New York, 1982.

Misfeldt WE: *The Albums of James Tissot*. Bowling Green University Popular Press, 1982.

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Ohio Medi-Scene

Comedy doc

A Kentucky psychiatrist figures he can make some medical advances with a few laughs. Clifford Kuhn, MD, thinks that laughter is therapeutic and wants to teach his medical students at the University of Louisville how to use it for their patients. But first he wants to find out what makes people laugh.

So, he traded his classroom lectern (the university gave him a sabbatical to do his research) for a comedy club stage. For the next few months, the psychiatrist will tour cities across the country to do routines at clubs. He also will interview comedians along the way to study their routines. He recently brought the house down in Dayton with jokes like, "Once a patient burst into my office complaining he was a deck of cards. I said, 'I'll deal with you later.' "

Dr. Kuhn is a follower of Norman Cousins, an author who called laughter a natural painkiller in the mid-1970s. Dr. Kuhn, who studies the psychological impact of diseases such as cancer and arthritis, agrees that laughter reduces stress and pain.

He encourages his students to prescribe at least 20 minutes of laughter a day to their patients.

Dr. Kuhn believes laughter helps bolster the immune system. "It's not a panacea," he warns, but "it is a health habit that improves a person's ability for getting healthy or staying healthy." Did you hear the one about the . . . **OSMA**



Cancer hospital in the red

The Arthur G. James Cancer Hospital and Research Institute, located in Columbus, lost more than \$10 million in its first year and is expected to face more losses over the next three to four years. A \$4.7 million loss was expected the first year, says William J. Shkurti, acting vice president for finance at OSU, but delays in opening the \$61 million hospital pushed the figure even higher. And, since the hospital opened, administrators have found that more workers and suppliers have been needed than originally expected.

While a committee, composed of university trustees and hospital and university officials, works to curb the losses, some are looking to the state Legislature for help. The state originally planned to pay only the hospital's building costs, but university officials say they expect to receive financial help from the state, at least until the hospital starts making money, which may not happen for another three to four years.

Not all legislators agree that help will be forthcoming, however. Sen. Eugene J. Watts (R-Galloway)

says of the hospital: "It has been more difficult and more expensive than anyone anticipated, but we are talking about a state-of-the-art facility that benefits us all. At some point, however, they have to solve their own problems. We don't want to end up with one of those endless funding issues that never go away." **OSMA**

Campaign steps up against drunk drivers

Ohioans with five or more drunk driving convictions may soon find themselves on a State Highway Patrol "hot list." The patrol will compile the list of repeat offenders so troopers can more accurately identify drivers whose licenses might have been suspended or revoked because of convictions for drunken driving.

More than 8,500 people in Ohio have been convicted five or more times of drunken driving and, in the past 10 years, 53% of all drunken driving violations in the state were committed by repeat offenders.

The list will be initially composed of repeat offenders in Butler, Licking, Portage, Summit and Wood counties. These counties were chosen to test the program because of their diversity in location and population. However, the program is expected to spread throughout all 88 Ohio counties soon. **OSMA**

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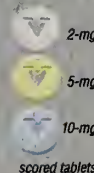
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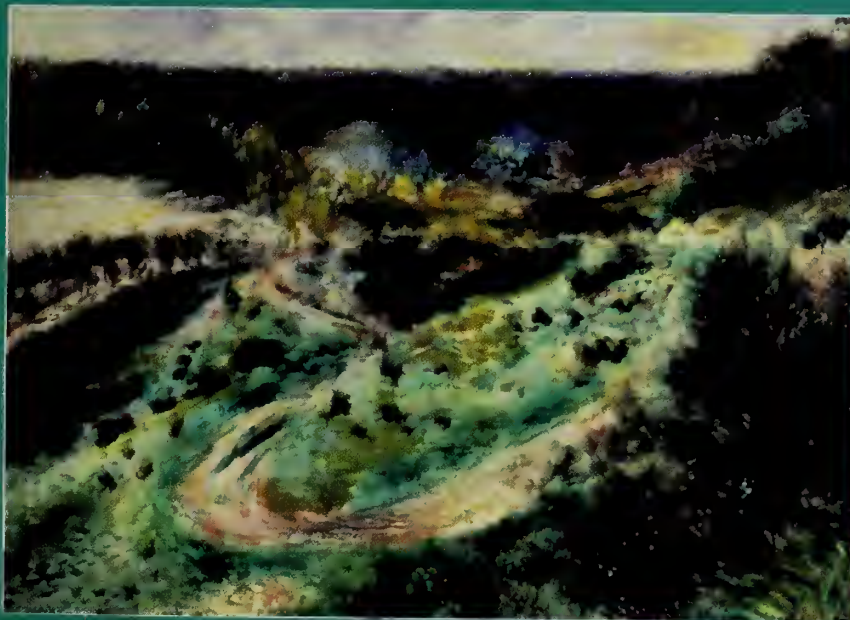
OHIO Medicine

JOURNAL OF THE OHIO STATE MEDICAL ASSOCIATION

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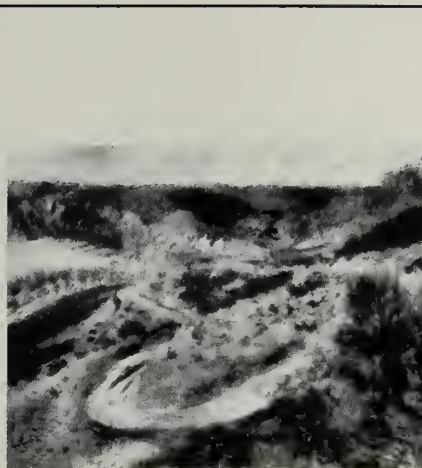
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Landscape was an important subject for Renoir. "Road at Wargemont" painted in 1879 depicts a twisted road curving through the Normandy countryside without any special feature to attract the viewer's attention. It was painted rapidly in thin oil paint. One critic called this Renoir's greatest landscape. Photo courtesy of the Toledo Museum of Art. Story on Page 552.

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in all the major democracies of the world, Americans are the least likely to bother with the process of voting.

In fact, in America, voter participation has been steadily decreasing

since 1960. In the last general election, almost two-thirds of the country's registered and eligible voters failed to cast ballots — and that doesn't even begin to account for those thousands and thousands of citizens who aren't even registered.

Perhaps the most surprising news of all is that doctors are no exception.

Physician participation in the

legislative process seems to be following the same general non-voting trend as the rest of the country, and that's discouraging — not only for medicine but for the democratic process as a whole. It seems ironic that, at a time when half the world is learning to appreciate the tenants of a democratic society, *this* democratic society is turning its back on our very underpinning of freedom, that is, our ability to *elect* our own leaders.

In 1990, at the OSMA House of Delegates' Annual Meeting, voter registration cards were distributed before the opening of the Final Session. An unbelievably large number of cards were returned, which leads me to believe that there is an even greater number of physician-members out there who have moved or perhaps for some other reason failed to register with the Board of Elections. If you are one of those physicians, I encourage you to take care of this oversight as soon as you can.

Then, as a newly registered voter, cherish and exercise your rights and go to the polls this month and vote. This year's election may not be as spectacular as next year's promises to be, but by voting *this* year, you'll reinforce your Pavlovian response, i.e. November means "Vote"!

Next, I would encourage you to make one further step. Become

**Joseph Sudimack,
Jr., MD**
OSMA President



Presidential Perspectives

involved in the political process. As the health-care reform issue heats up in Ohio, the OSMA will need you and all of its members to help shape the direction that reform will take. Lick stamps and envelopes, knock on doors and hold "tea parties" for your favorite candidates. Educate and involve your family members when possible. For your children, this is a lesson in Americanism.

Another way to become more involved in the legislative process is through the Ohio Medical Political Action Committee (OMPAC). Lately, OMPAC participation has been experiencing a decline (although auxiliary participation has improved slightly), despite

increased efforts by the OMPAC Board and its capable chair, Jerry Kimmelman, MD. Even though we're still recognized as one of the six biggest PACs in the country, if we don't dig deeper and more frequently into our pockets, we will be left in the dust. As true patient advocates, we must sacrifice in order to assure the continuity of quality care for Ohio's citizens.

Next year, our legislative friends will be more important to us than ever before. The number of bills introduced into the legislature, dealing with contemplated health-care reforms is frightening. We must be able and willing to support them if we expect to

receive any support from them in return. So, if you're not already a member of OMPAC, send in your check now. Your voice and your vote may be just the one to make a difference.

Don't forget this important part of our heritage and never, never forget Dr. Benjamin Rush and the other physicians who signed the Declaration of Independence. It's time to stand up and be counted! **OSMA**



Sources for Clinical Clips

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Cases of rubella,
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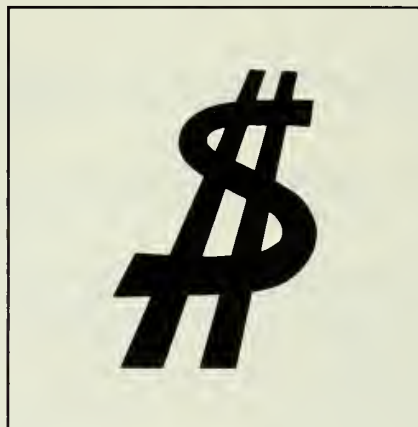
Letters to the Editor

Another Ohio medical heist

Editor's note: Thanks to OSMA's successful lobbying efforts, physicians who contributed to the SRF from 1976-1979 will receive a refund plus interest. But the SRF refund has been delayed by a lawsuit filed by the JUA board to prevent the state from taking \$45 million of the JUA's assets. The courts will now decide whether the state has a legal claim to the JUA's assets. Meanwhile, the OSMA continues to cooperate with the Ohio Department of Insurance in order to expedite the SRF refund for physicians.

To the Editor:

I have been very concerned about the fact that Gov. Voinovich's regime is apparently preparing to take the Joint Underwriter Association (JUA) reserve fund of approximately \$45 million for the Ohio General Operating Fund for 1991. These funds initially were contributed by physicians and hospitals so that they would have a reserve fund to provide for medical professional liability insurance in the mid to the end of the 1970s. We found that this money was derived from physicians and hospitals to provide insurance for people who could not obtain insurance during the last malpractice crisis. Also, there is an additional \$23 million to \$25 million in the Stabilization Reserve Fund that was also derived from contributions from physicians who were in practice in the state in the 1970s. This fund was derived from some insurance premiums and also from direct contributions made by physicians who were in practice in the state at that time, at the rate of, I believe, \$250 per year. I believe the funds were collected for three or four years. I think it



stopped in 1979.

I think you should be aware of this heist by your state government to move some of your money to the Ohio General Operating Fund. Apparently, a friendly lawsuit has been filed by the JUA to protest these funds from the governor. It appears that the governor believes these funds to be state funds, when actually they belong to the Ohio Medical Professional Liability Underwriting Association. Your interest should be paramount in protecting these funds from the governor. As you know, the Ohio State Medical Association has told you that there will be distribution of the remaining funds in the Stabilization Reserve Fund to practicing physicians from the '70s who contributed to this fund when it was operational. Let's hope that a skeleton group can remain in place with the JUA, so that if another malpractice crisis occurs, we will be able to mobilize the JUA again and put it back in business. Please also get ready for an increase in your medical malpractice rates. The carriers will not be able to generate as much money on their reserves as they have in the past, with falling interest rates, etc.

J. John Bock, MD
Columbus

Silica theory not proven

To the Editor:

In the Science and Education section of the August issue, a brief report states that "researchers have determined that particles of silica and not coal dust are to blame for the suffocating black lung disease." The use of the expression "have determined" implies that this is the last word on the subject; I believe that it is not. This is a controversial topic that has been studied for many years, and will probably be studied for many more. Dr. Van Dyke feels that since carbon is a normal constituent of the human body, carbon in the form of coal cannot be toxic. Applying this logic, I guess carbon monoxide is not poisonous.

George White, MD

Greater Cincinnati Occupational Health Center
Cincinnati

OHIO Medicine

welcomes Letters to the Editor.

Executive Editor

OHIO Medicine

1500 Lake Shore Drive

Columbus, Ohio 43204-3824

Whose Quality of Care Is It, Anyway?

PHYSICIANS, NOT
HOSPITALS, ASSUME MOST
OF THE LIABILITY

By Emerson Laird, MD

As a member of a hospital medical staff, there are two things you must be able to do before your staff privileges are renewed. First, you must verify

that you are insured for malpractice, then you must assure hospital administrators that your policy meets the dollar coverage they have set.

But where are the hospitals' assurances to *you* that they are making every effort to decrease liability by

promoting quality of care?

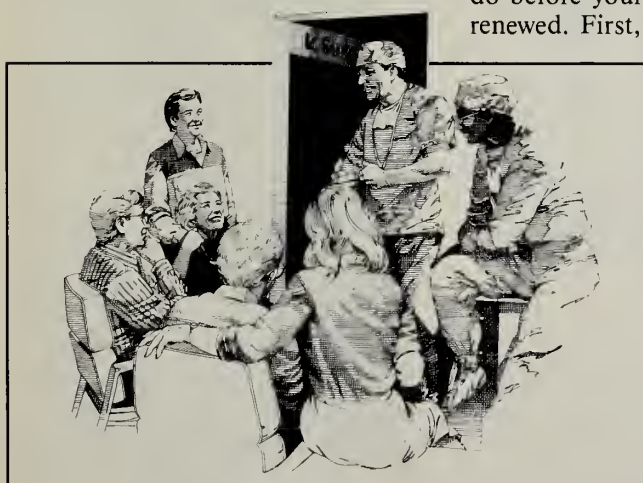
Unfortunately, such assurances are becoming harder and harder to come by. Hospitals, looking to enhance their bottom line and lulled by the knowledge that any

liability risks can be adequately financed through their medical staffs, have begun to explore creative management styles — ones, for example, that allow the duties of hospital employees, lost by attrition or other means, to be absorbed by remaining employees and/or medical staff; or that trigger an exodus of hospital employees on low-census days, leaving essential hospital services understaffed. As a result, physicians are left scrambling to provide what often amounts to compromised care. Yet it's the physician — not the hospital — who is held accountable for this care.

Isn't it about time, however, for physicians to quit bearing the burden of professional liability created by undocumented *hospital* errors? Isn't it time for physicians to stop accommodating a peer review system that inappropriately faults physicians for what are actually *hospital* quality care issues?

Fortunately, the issue of hospital errors is being addressed by Peer Review Systems, Inc, Ohio's contracted peer review organizations. PRS acknowledges, in a letter written by its senior vice-president of medical affairs, Steven L. Richardson, MD, that "the difference between hospital and physician-only errors are practically impossible to distinguish," but that "it rarely is

Continued on page 555



From Our Editors

Are You Ready? Are They Ready? Do You Belong?

FACING THE '90s

TOGETHER

The '90s will prove to be volatile for practicing physicians. Are you ready? The cost of practicing medicine will continue to rise, and incomes will fall. Hassle factors have already become a given in the daily performance of medical duties. The development of practice parameters will tend to standardize the practice of medicine. Major assaults will

continue to be made on physician autonomy with a resultant decline in the amount of satisfaction received from the practice of medicine.

The first major obstacle of the '90s for physicians is just around the corner. The Department of Health and Human Services (DHHS) has made a proposal to implement a new law changing the way Medicare pays physicians and other providers. The changes implemented by the department's Health Care Financing Administration (HCFA) by law will take effect on January 1, 1992. Are they (HCFA) ready?

By anyone's standards, the start-up and management of a new physician payment method is an immense challenge. In addition, the past decade has been a decrease in HCFA's work force of nearly 1,000 employees. Medicare's prospective payment system for hospitals will seem like child's play, compared to the new physician payment plan, which includes 7,000 procedure codes that identify services provided by 500,000 physicians that will generate some 450 million bills annually.

In addition to the new physicians' fee schedule, simultaneously other changes are being implemented that will impose additional stringent constraints on growth of reimbursement to physicians and tighten limits on balance billing by non-participating physicians.

The physician's dependence upon and the power of organized medicine has never been more important in the modern history as it is practiced in America. When our government needs input from the medical establishment, it turns more and more to the federation of medicine — local medical societies, state societies and the AMA. Do you belong?

The physicians of the 21st century will be a composite of those who have gone before. They will be compassionate, cooperative, bold and cost-effective. Are you ready? **OSMA**

By William J.
Marshall, MD
Member of OHIO
Medicine's
Advisory Board



AIM HIGH

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Association News

OSMA co-sponsors steroids video

Thanks to a \$4,000 donation by the OSMA Council, the videotape, "Steroids: A Hollow Victory," will be produced and distributed to high schools in Ohio.

OSMA joined forces with Lima Memorial Hospital, The Huntington National Bank and the Allen County Medical Society to make this possible.

"Anabolic steroid use is a very critical issue in sports medicine today," says Robert Clinger, OSMA director of the Department of Medical Society and Member Relations. "Research indicates the very negative effect anabolic steroids have on an athlete's health. The message of these dangers needs to be circulated around the state," he says.

Delphis C. Richardson, MD, chair of the Joint Advisory Committee on Sports Medicine, echoes similar sentiments: "The committee felt tremendous concern for the issue of use and abuse of anabolic steroids found in high school age athletes. The best way we could try to deal with this problem with our limited resources and manpower was to produce a video that could be distributed to every school in Ohio. Steroids are still a hot issue and there are still many misconceptions," Dr. Richardson says.

You may recall two years ago the OSMA co-sponsored a similar video, "Giving Your Mouth A Sporting Chance," which was distributed to the 816 member schools of the Ohio High School Athletic Association. That videotape, produced by the Council on Health Information in Central Ohio, received "thumbs up" reviews.

On the heels of that successful effort, the Joint Advisory

Committee on Sports Medicine served in an advisory capacity during the past year with representatives of the Allen County Medical Society and Lima Memorial Hospital in their production of a videotape on the dangers of anabolic steroid use by young athletes. Roger L. Terry, MD, of Lima, spearheaded the effort. The committee also sought the advice of John A. Lombardo, MD, drug adviser to the National Football League and director of the Department of Family Medicine at The Ohio State University. Dr. Lombardo also donated his time to appear in the video.

The videotape has been sent to the National Federation of State High School Associations (NFSHSA) for consideration of nationwide distribution. The initial response from the NFSHSA was favorable.

For additional information on the videotape contact: Roger Terry, MD, or Gail Freidhoff, PT, ATC at Lima Memorial Hospital, (419) 226-5075. **OSMA**

Video answers living will questions

Hoping to make the living will issue a little bit clearer, the OSMA, in cooperation with the Ohio State Bar Association, has produced a 10-minute video.

The two association presidents, Joseph Sudimack, Jr., MD, of the OSMA and Richard Markus, president of the Ohio State Bar Association, are featured in the introduction.

The video anticipates questions



that the living will and durable power of attorney forms will generate and has legal and medical experts on hand to answer the questions posed by the actors.

"This will make a handy tool for the physician/lawyer teams who will be addressing the media and community groups on the implementation of the living will law," says Carol Mullinax, OSMA's Communications director. Any physician making a presentation on this subject can also obtain the video for his or her use. Hospitals, nursing homes and other health-care facilities are also being approached about using the video in cooperation with their patient education programs.

Those interested in more information about the video may contact the OSMA Communications Department at (800) 766-OSMA. **OSMA**

Association News

OHIO Medicine gets new look

Big changes are coming in January when *OHIO Medicine* gets a new look.

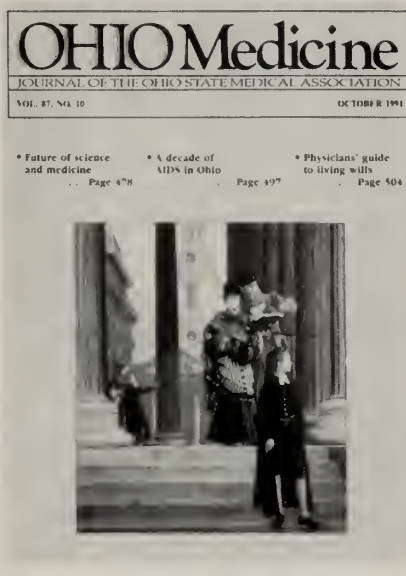
As of January 1992, *OHIO Medicine*, the *OSMAgram*, the *Legislative Bulletin* and *Third-Party Update* will be merged into one, 20+ page, monthly tabloid publication, retaining the name *OHIO Medicine*.

The new *OHIO Medicine* format will be more news-oriented. Articles will be short, direct and up-to-date. Articles on legislative, legal and reimbursement issues will continue to be plentiful in the new design. Along with your favorite articles, graphs and charts will be interspersed to make information more accessible.

The tabloid will be produced camera-ready in-house on a desktop publishing system that will not only save money, but will drastically reduce the turnaround time for the publication. This means the tabloid could be revised up until the minute it is sent to the printer. What that means to you, the reader, is late-breaking information.

Within a few months, interested county medical societies will have the opportunity to publish two- to four-page inserts in the publication. This would be accomplished by breaking the mailing list down by county, giving the reader information from around the state and around the county all in one publication.

The decision to make the change from magazine to tabloid was a directive from the OSMA Council's Long-Range Planning Committee. Based on a readership survey and focus group interviews held over the spring and early summer, *OHIO Medicine*, despite changes, continued to suffer from



poor readership. OSMA Council asked the Communications Department to evaluate all member communication activities and to report back to them in September on improving their effectiveness.

Throughout the summer the Communications staff was involved in an in-depth study of all OSMA member publications, seeking ways to streamline these publications and make them more readable and cost-effective. The result was a tabloid.

This new venture has received approval from the *OHIO Medicine* Advisory Committee and the Communications Committee.

Keep an eye out for the new *OHIO Medicine*. We hope you like what you see. Let us know what you think about the new format. **OSMA**

Continuing Medical Education

Ginzberg addresses health policy

"Health Policy: The Old Era Passes, the New Approaches" is the topic of the second annual Midland Lecture, to be held November 13 in the auditorium of Ohio State University's Fawcett Center for Tomorrow, 2400 Olentangy River Rd., Columbus.

The lecture, to be delivered by Eli Ginzberg, director of Columbia University's Eisenhower Center for the Conservation of Human Resources, begins at 4:30 p.m. and is open to the public. There is no charge.

Mayfield Neurological Institute Four-State Neuroscience Conference . . . November 16 (also January 25 and March 21) . . . Medical Sciences Building, University of Cincinnati Medical Center . . . 513-558-3558 or 1-800-325-7787 for information.

Nutrition for Clinical Practice and Everyday Living, 1991 . . . December 7-8 . . . Hyatt on Capitol Square, Columbus . . . 1-800-492-4445 for information.

Third Annual Postgraduate Endocrine Update: Endocrine Cancers . . . Holiday Inn Crown Plaza, Columbus . . . 1-800-492-4445 for information.

MS in the 1990s: A Multidisciplinary Approach . . . Dana Center, Medical College of Ohio, Toledo . . . 1-800-368-7549 for information.

Association News

AMA sets policy on infectious disease and health-care workers

The House of Delegates of the American Medical Association recently set as policy two recommendations concerning infectious disease. The first has to do with health-care workers and hepatitis B infection; the second with patients infected with the HIV virus.

The official policies read as follows:

Health-care workers and hepatitis B virus infection

- That any health-care worker who is infected with HBV and in whom HBeAg can be demonstrated should abstain from performing invasive procedures that pose an identifiable or measurable risk of transmission.
- That all health-care workers who are at risk of infection with hepatitis B virus (HBV) should be fully immunized with HBV vaccine.
- That for the purposes of these recommendations, a "health-care worker" be considered as any person involved in patient care in a paid capacity or as a volunteer and as a student, resident, trainee or trained worker.

HBV infection is a recognized risk for health-care workers who have not been immunized. As compared to the general population, health-care workers have a three- to five-fold higher prevalence of HBV infection. It has been estimated that annually there are from 7,000 to 8,000 new cases of HBV infection among health-care workers. Serologic evidence of HBV infection has been found in about 15% of health-care workers, and an average of 0.6% are HBV carriers (HBsAg+); of these approximately

20% are HBeAg positive. The presence of HBeAg in blood is associated with high levels of infectious virus and, consequently, with greater infectivity of infected persons. It is not known how many HBV-infected health-care workers perform invasive procedures. HBV-infected health-care workers have been documented as having transmitted infection to susceptible patients.

Although there currently is no approved therapy for HBV infection, it can be prevented through vaccination. Not only will vaccination protect health-care workers from infection, but also from the possibility of the unwitting transmission of the virus to their patients and their loved ones. The association previously adopted a policy that required that all students entering medical school be immunized with HBV vaccine and supported the proposed regulation of the Occupational Health and Safety Administration, requiring the vaccination of all health-care workers at risk of HBV infection.

HIV seropositive patients

- That the American Medical Association encourage patients who are HIV seropositive to make their condition known to their physicians and other appropriate health-care providers.

It is important that physicians know all the diagnoses of their patients and, further, it is in the best interest of infected patients that their physicians know all the factors. **OSMA**

Colleagues

Gita P. Gidwani, MD, Cleveland, has been elected president of the North American Society for Pediatric and Adolescent Gynecology. Dr. Gidwani was appointed to the one-year term during the society's fifth annual meeting held in Fort Lauderdale.

Glenn C. Hamilton, MD, Dayton, has recently received the 1991 Academic Leadership Award of the Society for Academic Emergency Medicine, the field's highest honor. The award recognizes Dr. Hamilton's contributions to the development of emergency medicine as an academic discipline. He presently serves as professor and chair of emergency medicine at Wright State University School of Medicine.

Joe N. Hackworth, MD, Cincinnati, was installed as President of the Academy of Medicine of Cincinnati at the Academy's 1991 Annual Meeting, held in September. Dr. Hackworth is the Academy's 135th president.

Association News

Physicians achieve national attention

It's not everyday a fellow physician becomes president of a national organization but it was brought to *OHIO Medicine's* attention recently that the state of Ohio is blessed with many physicians who have achieved this national recognition.

The seven physicians include:

Antoinette Eaton, MD,
Columbus, President of the
American Academy of Pediatrics

C. William Keck, MD, Akron,
President of the American Public
Health Association

Glen Aukerman, MD, Jackson
Center, President of the American
Academy of Family Physicians

Donald Senhauser, MD,
Columbus, President-elect of the
College of American Pathologists

Grant Morrow, III, MD,
Columbus, Chair of the American
Board of Pediatrics

Richard Ruppert, MD, Toledo,
nominated for President-elect of
the American Society of Internal
Medicine (elections will be held
later this month at the group's
annual meeting)

Wilma Bergfeld, MD, Cleveland,
President-elect of the American
Academy of Dermatology

We know there many, many Ohio physicians who are actively involved in various organizations in their communities and state. *OHIO Medicine* features these physicians in our Colleagues Column. We know there may be others out there who are also involved with a national organization — this is just a sampling from around the state. Congratulations to all our dedicated physicians who somehow manage to find time in their busy schedules to direct a national organization. **OSMA**

Clinical Clips

17,458

Number of male medical school applicants in 1990-91

11,785

Number of women applicants

10,550

Number of men accepted into medical schools

6,656

Number of women accepted

50.3%

Percentage of women residents in pediatrics

50.2%

Percentage of women residents in child psychiatry

46.4%

Percentage of women residents in dermatology

44.2%

Percentage of women residents in obstetrics/gynecology

31%

Percentage of women residents in family practice

27.4%

Percentage of women residents in internal medicine

131

Number of reported cases of rubella in Ohio in 1990

129

Number of those cases occurring in Amish communities

147

Number of reported cases in Ohio as of May 6, 1991

7,394

Number of influenza cases reported in Ohio from October 1990 through March 1991

35%

Percentage of decrease from 1989-90

30

Number of cases of mumps reported in Ohio between January 1 and March 31, 1991

Sources on Page 524



MEDICINE MEN

The Ohio Statehouse. The men and women in its chambers are not physicians. Yet, everyday our state's senators and representatives make critical decisions about legislation that can affect the quality of medical care and your rights as an independent professional.

Organized medicine's message must be heard. Our elected representatives must make informed decisions about health care issues. OMPAC, the political action committee of the Ohio State Medical Association, lets you be an active part of the force that assures your views, and those of your patients, are heard when government actions affect the practice of medicine and the delivery of quality health care. Through your contribution to OMPAC, you can support legislative candidates whose voting records and personal philosophies reflect a willingness to listen and support the views of organized medicine.

Support OMPAC.

Make an investment for yourself, your patients and your profession.

----- Clip and Mail -----

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Check One:

- ☐ Yes, I want to be a Sustaining Member of the Ohio Medical Political Action Committee. Enclosed is my personal payment of \$125.
- ☐ Better yet, both my spouse and I would like to be Sustaining Members. Enclosed is our payment of \$200.
- ☐ Resident or student \$10

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All contributions must be on personal check, or charge to your Visa or MasterCard

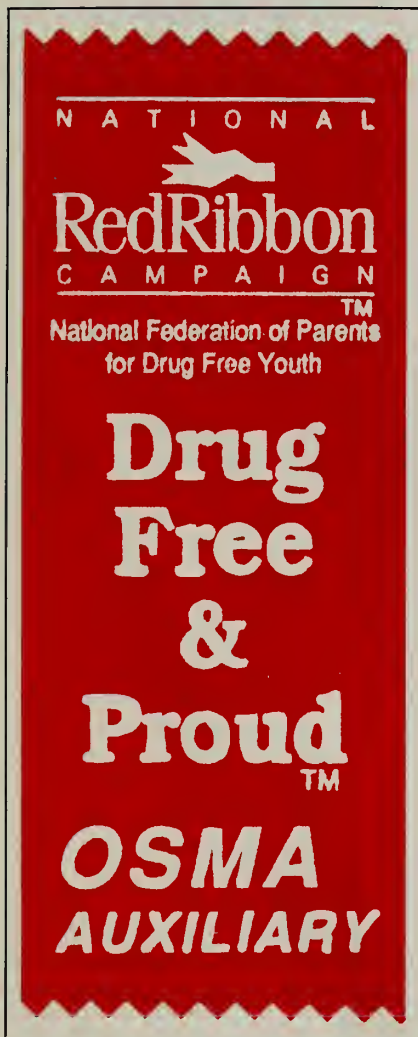
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1500 Lake Shore Dr.
Columbus, OH 43204

OMPAC is a separate segregated fund established by the OSMA. It is connected with AMPAC, a separate segregated fund of the AMA. Voluntary political contributions to OMPAC should be written on personal checks. Contributions are not limited to the suggested amount. Neither AMA, OSMA, nor county medical societies will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Voluntary political contributions are subject to the limitations of FEC regulations. This solicitation by OMPAC is not authorized by any candidate or candidate's committee. Contributions to OMPAC and AMPAC are not deductible as charitable contributions for federal income tax purposes.

Seeing Red



RED RIBBON CAMPAIGN MAY HELP MORE TOWARD A DRUG-FREE AMERICA

By Joyce Penn
OSMA Auxiliary President

When President George Washington, in 1789, proclaimed a national day of thanksgiving he hoped for a prayerful time, observed by all religious denominations. Looking back on our young country's long and turbulent colonial history and costly war for independence it was fitting for the pilgrims to enjoy nature's harvest and celebrate liberty.

Proudly sharing in this celebration today, we enjoy our prospering land but are faced with another war, an insidious battle against drugs and alcoholism. According to the National Institute on Drug Abuse (NIDA) the average age of experimenting with drugs is 12 years. Thirty-nine percent of high school students have used illegal drugs and 65% of young persons entering the workforce have used them. The pervasiveness of these problems among our population has led to enormous monetary and societal costs borne by all of us.

This year, the American Medical Association, addressing the prevalence of violence and its consequences to society, has asked for the auxiliary's help in getting physicians involved in making their communities less violent. The homicide rate in black males, aged 14 to 18, has increased over 40% since 1984. Violence is the third leading cause of death in children and often involves substance abuse.

Responding to a request from Mrs. Robert Taft, president of the Ohio Parents For Drug Free Youth, to participate in National Red Ribbon Week, October 19-27, 1991, auxiliaries statewide worked toward influencing our youth to develop healthier lifestyles. Nearly 9,000 imprinted ribbons were distributed to physicians throughout Ohio for their staff and patients to wear during the week. Funded by OMERF, the ribbon presents a unified and visible commitment toward the creation of a drug-free America.

Expanding upon the project and fulfilling the requests of additional physicians, The Academy of Medicine of Columbus and Franklin County supplied several thousand additional ribbons, theme balloons and a coloring book, "Be A Winner: Shape Up For Life." This book, compiled by the AMA Auxiliary, provides educational statements and illustrations about the harmful effects of drug and alcohol use. Auxiliaries regularly distribute

Continued on page 566

Legislation

Interest renews in paddling bill

A bill banning corporal punishment in schools, Senate Bill 86, sponsored by Sen. Richard Schafrath (R-Loudonville), may enjoy renewed interest *this* month after members of the National Coalition to Abolish Corporal Punishment in schools convened in Columbus *last* month for a special meeting on the issue.

Although that group has chosen to focus on a national paddling ban, the fight for a modified statewide ban continues here in Ohio as Sen. Schafrath's bill winds its way from the Senate to the House.

SB 86 specifically prohibits corporal punishment in Ohio, effective September 1, 1992, unless a school board legislates corporal punishment as part of its system's disciplinary policies.

Cynthia Snyder, associate director of OSMA's Department of State Legislation, was quoted in the June issue of *OHIO Medicine* as saying SB 86 was a political compromise, but the next best thing to achieving AMA and OSMA policies opposing corporal punishment of any kind.

Chances for passage for the bill by the end of the year look promising.

The bill was approved by the Education, Retirement and Aging Committee in May, but was not scheduled for a vote until after the summer recess. When legislators returned in September, Senate leaders told Schafrath they wanted some assurances that the bill would move through the House before they voted on it.

Rep. Judy B. Sheerer, (D-Shaker Heights), is working to gain House votes for the bill.

Ironically, however, the Ohio Center for More Effective School

Discipline reports that the percentage of Ohio teachers paddling students has dropped from nearly 5% in 1978 to 1.5% in 1988. Under the old figures, Ohio was ninth highest in the nation in the number of students paddled. Almost 44,000 students were paddled during the 1978-88 school year.

A 1985 law change in Ohio, however, allowed individual school districts to ban paddling, and Columbus, Cleveland, Cincinnati and Dayton were among those that did. As a result, the number of students paddled in the 1985-86 school year dropped to about 26,000.

The bill's proponents hope that, as fewer teachers turn to corporal punishment as a way to discipline students, there will be less opposition to legislation calling for a statewide ban. **OSMA.**

Legislation committee reviews Wayne Jones bill

As far as OSMA's Committee on State Legislation is concerned, there are parts of HB 478, the "Wayne Jones health-care reform" bill, they can live with — and parts they can't.

The bill was separated into sections at the committee's September meeting so that each element could be discussed on its own merits.

"This bill is composed of complex ideas," says Richard Wiseley, MD, Toledo, who chairs the committee. "It would be difficult to wholly support it or oppose it."

The first section to come under scrutiny was the proposal prohibiting radiologists, pathologists, anesthesiologists and emergency physicians from billing patients, requiring these specialists to bill through the hospital instead.

Committee member Thomas Seward, MD, a radiologist from Terrace Park, said that the Ohio State Radiology Association will be actively working with the other specialty groups named to defeat this section of the bill, and hoped that the OSMA would support their efforts. Dr. Wiseley appointed a subcommittee to work with the specialty groups to accomplish this end.

With regard to provisions dealing with cost-containment issues, the committee voted as follows:

- A provision requiring third-party payors to set a minimum level for physicians, hospitals and other health-care providers at 110% of the amount that Medicare reimburses — **Active opposition.**
- A provision prohibiting balance billing for all specialists

Legislation

(excluding primary care physicians, family physicians, etc.) This provision would apply across the board, not just to Medicare patients — **Active opposition.**

- A provision prohibiting physicians from referring patients to clinical labs where they have financial interest. (This provision is said to be similar to a new federal law that prohibits referral of Medicare patients to clinical labs. (The exceptions to that federal prohibition, known as the “safe harbor” rules, were just recently published.) HB 478 would apply to all payors, not just to Medicare — **No position with technical assistance.**

With regard to five provisions that deal with increased accessibility through health-insurance reform, the committee voted to support all five with technical assistance. Two provisions were singled out for active support. They were:

- A provision requiring caps on insurance company administrative expenses at 20% (in other words, insurance companies would have to pay out at least 80 cents on every premium dollar collected).

- A provision providing physicians with a qualified immunity from liability when treating patients without compensation in certain clinics or shelters for the homeless.

HB 478 is presently being reviewed by the House Select Committee on Health Care Reform. *OHIO Medicine* will keep you apprised of its progress. **OSMA**

How the legislation committee voted on new agenda items

In addition to considering HB 478, the OSMA Committee on Legislation, chaired by Richard Wiseley, MD, of Toledo voted on several other bills that are now being considered by the Ohio Legislature. Here is a rundown on how the committee voted:

House Bill 419 — Physicians report HIV status

Requires physicians and other health-care professionals who test sero-positive for HIV or have been diagnosed as having AIDS to inform the Ohio Department of Health, the appropriate licensing board, the hospital or health-care facility where the practitioner has privileges or is employed and certain patients.

Committee action: **Active support provided that physicians also have the right to test patients.**

House Bill 454 — Medical licensure revisions

This bill would change the date for renewal of certificates to practice medicine; makes changes in the requirement for admission to the State Medical Board's examination for certification to practice; modifies the requirement that graduates of foreign medical schools must take a test of spoken English, and provides for various types of limited certificates to practice medicine.

Committee action: **Active support with technical assistance.**

House Bill 448 — Medically fragile children/Medicaid increase for physicians

This bill would require the

Medicaid program to develop and provide home- and community-based services to medically fragile children without regard to income level, also requires the licensing of pediatric daily care centers, and authorizes the use of certain funds to increase Medicaid

reimbursement to physicians up to 90% of usual, customary and reasonable charges for obstetrical and gynecological services and pediatric services for children under age one.

Committee action: **Active support with technical assistance.**

House Bill 404 — Social workers receive insurance reimbursement

This bill adds services performed by licensed independent social workers to those performed by psychiatrists and psychologists under coverage for mental and emotional disorders in health insurance policies and health care plans.

Committee action: **Active opposition with technical assistance.**

House Bills 425 and 469 and Senate Bill 184 — Immunity for physicians treating indigent persons.

All three bills would provide qualified immunity from medical malpractice liability for physicians who provide free diagnoses, care and treatment to indigent or other uninsured patients.

Committee action: **Active support with technical assistance.**

Legislation

Redistricting will have impact on medicine

Whether or not the dust has finally settled on the reapportionment issue by the time you read this, one thing is clear. This is one very important political football that is bound to influence the make-up of the Ohio Legislature and, ultimately, to affect the future of health-care legislation in the state.

Redistricting happens every decade after the census is taken. National population shifts to the South and Southwest dictate that Ohio, where the population stayed about the same, will lose two congressional districts, reducing Ohio's congressional delegation from 21 to 19. In the Ohio Legislature, all 99 Ohio House and 33 Ohio Senate district seats will be redrawn by the State Apportionment Board. By winning the offices of Governor and Secretary of State, the Republicans will control the redistricting process for the first time ever.

As of this writing, new lines had not yet been drawn, but all appearances seem to indicate that the predominately Democratic areas of Cleveland and Youngstown would lose seats, while the largely Republican Franklin and Hamilton counties stood to gain.

"Republicans, led by Senate President Stanley J. Aronoff of Cincinnati, should be able to maintain control of the Ohio Senate for many years to come," says John Van Doorn, director of OSMA's Department of Legislation.

Meanwhile, Republicans are doing what they can to make inroads in the Democrat-controlled House. First, the Republicans are

hoping that the new districts will be favorable to their candidates. Secondly, they are raising money to fund the campaigns of their challenger-candidates. Standing in the Republican's way is Vern Riffe of Wheelersburg, Speaker of the Ohio House, and the top Democratic office-holder in the state. Although outvoted on the Reapportionment Board and therefore unable to change districts to help Democrats, Speaker Riffe and his House Democratic caucus will be difficult for the Republicans to unseat, says Van Doorn. Democrats have been able to maintain a majority in the House for two decades, and they have exhibited through the years considerable skill at campaigning.

While the new districts have not yet been drawn, it is certain that some districts will include the residences of two or more current state legislators.

"For us, problems arise when one legislative friend of medicine is pitted against another friend," says Van Doorn. "That means we're going to lose one."

And timing couldn't be worse for losing friends.

"The biggest campaign issue of the 1992 elections will be health-care reform," says Van Doorn. "Medicine can use all the friends we can find."

He also sees the 1992 elections as pivotal for medicine in another way.

"The requests for support from our legislative friends will be at an all-time high," he says. "We have to be in a position to assist legislators who have consistently supported our issues."

The Reapportionment Board will soon reveal, if they haven't already, which of medicine's friends will remain in the game.

The legislative staff, as well as

members of the board of the Ohio Medical Political Action Committee (OMPAC), chaired by Jerry Kimmelman, MD, Toledo, will be monitoring the players closely from now until the November 1992 elections. **OSMA**

Reimbursement

What Ohio doctors need to know about RBRVS

If the federal government's prospective payment system goes into effect in January as planned, how will Ohio's physicians be affected?

That was the question James Cuppy of Nationwide/Medicare attempted to answer for a group of county medical executives who met this past summer at the invitation of the OSMA.

Referring to the Resource-Based Relative Value Scale (RBRVS) as the "beginning of the beginning," Cuppy made one thing clear from the start.

"Your members aren't going to like the reimbursement levels," he said with characteristic bluntness, "but at least the figures will be computed accurately."

The figures, of course, are based on a complicated formula that assigns a relative value to each procedure a physician does, factoring in such elements as practice expense and liability, then multiplying this result by a conversion factor. From this, a Medicare fee schedule amount is derived.

The good news is that this fee schedule has the potential of standardizing Medicare reimbursements across the country, correcting any disparities that may exist from one region to the next.

"Ohio is divided into 15 localities," says Cuppy. "Each locality will be reimbursed at slightly different levels, although some interest has been expressed in going to a statewide reimbursement system."

State vs. locality payment

In fact, Ohio was one of several states that HCFA believes should go directly to a statewide fee schedule because of low deviations



James Cuppy of Nationwide Medicare explains RBRVS

in its geographic practice cost indices. For example, in Ohio, the average amount of an office call is \$26.87 — a price that fluctuates by only about 2.2% across the state. If a statewide fee schedule was implemented, all Ohio physicians would be reimbursed this amount for an office call for Medicare patients. That would mean, however, that some areas in Ohio would have to give up money they would be able to earn under the existing locality reimbursement system. According to Cuppy, that amount might run as high as 55 cents per office visit.

"No carrier is going to go statewide in the initial year unless there is a total commitment from the medical association that this is the way to go," says Cuppy.

In July, the OSMA Council voted to reject a statewide payment system, following in the steps of both Louisiana and West Virginia — two states that HCFA recommended follow a statewide payment plan but which also turned down the idea. Therefore, Medicare reimbursement will be

paid in Ohio according to the 15 localities.

"Medicare has just completed computing a history of charges for every procedure code, for every physician in every locality," says Cuppy. Take, for example, the procedure code 90050, limited office visit. Medicare took the first physician in locality one, computed the services rendered under that code from July 1, 1989 through June 30, 1990, as well as the amount billed under that code through that period, and developed a practice profile. Those profiles subsequently helped determine the locality's reimbursement levels.

"The information that went into figuring the data is disclosable," says Cuppy, "but it's not exactly useful." This "Summary Keeper File" will probably go to the state association and to the AMA to ensure that its calculations have been made according to law.

Cuppy doesn't hesitate to say that Nationwide/Medicare would have preferred to see Ohio physicians go to a statewide fee schedule.

Reimbursement

"It would have made our job easier, and eliminated the rural-suburban arguments," he says. However, reimbursement has already been calculated according to localities and Medicare is ready to go with that system in January.

In the meantime, Cuppy foresees problems — and a lot of unanswered questions — ahead.

"I suspect carriers would like to see a delay in this system as much as you would because there are a lot of issues that haven't been addressed yet," he says. And, more than likely, carriers will only receive a "moment's notice" before implementation.

Gray areas

One of the potential gray areas that Cuppy foresees is the "new" physician provision that will go into effect.

Historically, at least since 1985, newer physicians have been reimbursed at lower rates until they have been in practice for five Medicare years. Cuppy says Medicare considers physicians as "new" for a period of 18 months after they start practice. In other words, a physician who began practice on July 1 of this year would not be considered a second-year physician by Medicare until January 1993. Up until RBRVS, those new physicians who joined a group under Option II, a common fee-structure Medicare group, could be reimbursed at the group payment levels rather than their "new" physician lower rate. Under RBRVS, however, new physicians will no longer have that shield. Instead, they must be identified as new by the group, and they will be reimbursed at approximately 80%-95% of the group rate until they have completed their fourth full Medicare year.

Medicare constants

Three issues that *won't* change, however are:

1. The 5% reimbursement difference between participating and non-participating physicians.
2. Physician liability for medically unnecessary services.
3. The appeals process.

Cuppy says physicians can expect significant CPT code changes in 1992 if RBRVS goes into place — and as far as balance billing is concerned, the carrier will advise physicians what the limiting charges are.

"These limiting charges are serious," says Cuppy, "But they can be calculated fairly easily. Beginning Jan. 1, 1993 they are simply 115% of the nonparticipating fee schedule amount."

Two other constants will remain in place, says Cuppy in closing.

"The RBRVS formula derived by the government probably isn't going to change," he says. "And reimbursement levels aren't going to increase over current levels."

OSMA

Seminars clarify RBRVS questions

If you or your office staff are baffled about the Resource-Based Relative Value Scale (RBRVS) payment system the answers may be as near as your county medical society.

Various programs will be conducted around the state to answer some of these questions. Sue McGill, district manager of Ohio Medicare at Nationwide Insurance Companies, along with other Medicare representatives, will be making the rounds to county medical societies to field questions on this hot issue.

The Cleveland Academy of Medicine will present its afternoon seminar including a historical background on RBRVS along with information on "How We Got There and Where We're Going." Admission is free to members, nonmembers pay \$100. Local and national physicians will address the RBRVS issue.

Mahoning County Medical Society will welcome McGill as part of their general society

membership dinner/meeting featuring Physician Payment Reform as the topic. The meeting, free to members, is open to spouses and nonmembers for the price of the dinner.

The Academy of Medicine of Columbus and Franklin County will host a two-hour evening workshop on RBRVS and Physician Payment Reform with plenty of time allotted for questions and answers. Contact Libby Moore for details.

The November meetings are as follows:

- Nov. 2, Academy of Medicine of Cleveland, 216-229-2200
- Nov. 19, Mahoning County Medical Society, 216-788-4700
- Nov. 20, Academy of Medicine of Columbus and Franklin County, 614-766-6221. OSMA

Reimbursement

Survey reflects changing attitudes of young physicians

The majority of medical residents today receive over 50 offers of employment, expect to make at least \$100,000 or more their first year of practice and would prefer an HMO or group setting to a solo setting, according to a survey conducted by Merritt, Hawkins and Associates, a national physician search firm based in Dallas, Texas.

The survey of 100 third-year medical residents indicates a continued shift away from traditional patterns of practice, toward "9-to-5" medicine, says Joseph Hawkins, chief executive officer of Merritt, Hawkins and Associates.

"The days when physicians put out a shingle and spent 70 to 80 hours a week performing hands-on care are long gone," Hawkins states. "Physicians today expect different things from medical practice. They seek financial security and enough time away from work to enjoy life. Because demand for their services is so high, young physicians are in a position to obtain what they want."

Eighty-six percent of physicians surveyed had received at least 50 job offers, underscoring the current demand for physicians. Sixty-five percent of residents responded that they had received 100 or more job offers. Though many of these offers are from smaller, rural communities, 79% of residents surveyed would prefer to practice in mid- to large-sized communities. Only 5% of residents expressed a desire to practice in communities of 25,000 or less.

When asked which type of practice setting they would prefer,

69% of residents indicated either a group or HMO setting as a first choice. Only 8% of respondents preferred a solo setting, and only 5% preferred a partnership.

"Partnerships are where all the horror stories are generated," Hawkins observes. "Few physicians today want to risk a bad professional marriage."

The marginal preference for solo settings highlights an even more disturbing trend, says Hawkins.

"The doctor used to be the ultimate example of the small entrepreneur whose practice was not a job, but a way of life," Hawkins states. "Today, changing technology, bureaucratic hassles and malpractice worries have made solo practice seem like a trap to many young physicians. They prefer the support and security of HMOs or groups."

The trend away from entrepreneurial medicine also is reflected in the type of payment preferences that survey respondents revealed. Sixty percent of residents surveyed said they would prefer a salary as a form of compensation in their first practice. Twenty percent indicated a preference for an income guarantee. Only 15% preferred the standard fee-for-services form of payment by which physicians have traditionally been compensated.

"These payment preferences show the premium young physicians place on security and structure," Hawkins explains. "Because of convoluted third-party payor schemes, physicians today would prefer the structure of a regular salary. Since young physicians carry an average debt of over \$40,000, they also seek the security of an income guarantee."

The survey also indicated that residents have a good idea of their value in the marketplace. Ninety-

one percent of residents surveyed indicated that they expect to make at least \$75,000 to \$100,000 their first year in practice. Fifty-nine percent of residents surveyed expect to make \$100,000 or more. **OSMA**

Dayton subjects participate in Medicare survey

Is Medicare working? That's the \$168 billion dollar question.

Medicare participants in Dayton are letting government officials know what they think.

The U.S. Department of Health and Human Services, in an effort to examine the Medicare program, has chosen 136 beneficiaries in the Dayton area and 12,000 beneficiaries nationwide to help them answer that question.

The beneficiaries' job is to let the government know how Medicare does or doesn't work for them.

This is all part of a \$33 million study that is expected to improve the system. The survey should produce information that will help estimate the cost of future health-care legislation.

All answers given by the survey participants will be kept confidential, according to HHS officials.

The big question will be how the participants pay for health care (such as long-term nursing home care or prescription drugs) that isn't covered by Medicare.

A Maryland research company will send interviewers to participants every four months for at least three years. Participants in return will also be asked to share

Reimbursement

information about their health.

According to the survey team, the answers from the survey could lead to possible policy changes.

In fiscal year 1991 alone, the federal government is expected to spend about \$168 billion in Medicare and Medicaid benefits for 57 million people. **OSMA**

Consider advice before signing contracts

You have all probably heard horror stories about physicians who hastily signed contracts with blank terms that were filled in after the contract was signed resulting in terms that did not meet the physicians' needs or vague and open-ended terms that needed clarification.

Deborah Bahnsen, JD, who serves as legal counsel for OSMA's Ombudsman Department, offers analysis of third-party payor contracts as a service to OSMA members. The big concern right now seems to be "Super Blue" contracts.

This analysis is not to be taken as legal advice, nor will Bahnsen counsel you on whether or not to sign the contract. However, she will offer you some tips to keep in mind before signing a contract.

The best advice Bahnsen can give is, "Before signing a contract, know the right questions to ask." She explains that this is not always an easy thing to do. Many physicians and their office managers do not know what to look for in a contract and what questions to ask the payor. Allow yourself enough time to carefully read over the contract, jotting



down questions you need to ask, she suggests.

Bahnsen warns that you shouldn't be fooled by short and simple contracts. Those kinds of contracts can be deceiving, Bahnsen points out. "Actually, the simpler the contract the more complex the review has to be," she says. Those contracts have a tendency to generalize terms.

She points out that it's becoming important for physicians to understand fee schedules. "Historically, traditional big-name insurance companies paid Medicare copayments and deductibles. Now, insurance companies will say our fees are 'x' and we never pay more than 'x,' " she says.

Managed care contracts in general produce a red flag, according to Bahnsen. If a physician agrees to accept UCR fees under contract and these fees are less than what Medicare charges, physicians stand to lose money.

Understanding the circumstances by which you may have your contract terminated is important, too. It's important to know how your contract can be terminated. Not only is it important to know how a payor can terminate a contract, but how a physician can terminate also. In most cases if a party is notified in writing within a designated amount of time a

contract can be terminated, Bahnsen says.

Bahnsen also advises physicians to be cautious in the number of subscribers allowed into a practice. She is presently trying to help a physician who stands to lose almost half of his patients because his contract has suddenly been terminated.

For a complete list of do's and don'ts of contract signing please refer to the April 1991 issue of *OHIO Medicine* or contact OSMA's Ombudsman's Department, (800) 766-OSMA. **OSMA**

One Of A Kind



Zantac[®]
*ranitidine HCl/Glaxo 150 mg and
300 mg tablets*

Please see Brief Summary of Prescribing Information on adjacent page.

Glaxo/ 

Zantac® 150 Tablets
(ranitidine hydrochloride)

Zantac® 300 Tablets
(ranitidine hydrochloride)

Zantac® Syrup
(ranitidine hydrochloride)

CONDENSED BRIEF SUMMARY

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.
INDICATIONS AND USAGE: Zantac® is indicated in:
1. Short-term treatment of **active duodenal ulcer**. Most patients heal within four weeks.

2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.

3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).

4. Short-term treatment of **active, benign gastric ulcer**. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.

5. Treatment of **gastroesophageal reflux disease (GERD)**.

Symptomatic relief commonly occurs within one or two weeks after starting therapy and is maintained throughout a six-week course of therapy.

In active duodenal ulcer, active, benign gastric ulcer, hypersecretory states, and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1. An idiosyncratic response to Zantac® therapy does not preclude the presence of gastric malignancy. 2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although recommended doses of Zantac do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Pregnancy, Teratogenic Effects, Pregnancy Category B: Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: Headache, sometimes severe, seems to be related to Zantac® administration. Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and, rarely, pancreatitis have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, atrioventricular block, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid intravenously for seven days, and in 4 of 24 subjects receiving 50 mg qid intravenously for five days. There have been occasional reports of hepatitis, hepatocellular or hepatocellular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia have been reported.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdose and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling.)

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 mL/min is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30° C (59° and 86° F) in a dry place.

Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 mL in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25° C (39° and 77° F). Dispense in light, light-resistant containers as defined in the USP/NF.

September 1990

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Obituaries

FRED ADELSTEIN, MD,
Cleveland; University of Cincinnati College of Medicine, 1920; age 97; died August 22, 1991; member OSMa and AMA.

MICHAEL T. BROWN, MD,
Cincinnati; University of Cincinnati College of Medicine, 1946; age 67; died August 17, 1991; member OSMa and AMA.

HERBERT BRUMBAUGH, MD,
Dublin; University of Michigan Medical School, Ann Arbor, MI, 1929; age 89; died August 18, 1991; member OSMa and AMA.

CLARENCE H. EGBERT, MD,
Hamilton; Case Western Reserve University School of Medicine, 1943; age 74; died August 18, 1991; member OSMa and AMA.

RALPH I. FRIED, MD,
Cleveland; St. Louis University School of Medicine, St. Louis, MO, 1935; age 81; died August 13, 1991; member OSMa and AMA.

EMILY R. HESS, MD, Ft.
Thomas, KY; University of Cincinnati College of Medicine, 1943; age 83; died August 18, 1991; member OSMa and AMA.

RICHARD M. INGLIS, MD,
Toledo; St. Louis University School of Medicine, St. Louis, MO, 1956; age 62; died August 8, 1991; member OSMa.

MORTIMER LUBERT, MD,
Cleveland; Case Western Reserve University School of Medicine, 1940; age 77; died August 24, 1991; member OSMa and AMA.

RICHARD B. MULVEY, MD,
Cincinnati; University of Cincinnati College of Medicine, 1955; age 63; died July 30, 1991; member OSMa and AMA.

WILLIAM O'HALLORAN, MD,
Dayton; St. Louis University School of Medicine, St. Louis, MO, 1962; age 60; died August 29, 1991; member OSMa and AMA.

JOSEPH F. ORLANDO, MD,
Oregon; Facolta di Medicina e Chirurgia dell'Università di Bologna, Bologna Italy, 1957; age 67; died August 15, 1991; member OSMa and AMA.

BERKELEY SLUTZKER, MD,
Dayton; University of Illinois at Chicago Health Sciences Center, Chicago, IL, 1949; age 67; died August 30, 1991; member OSMa and AMA.

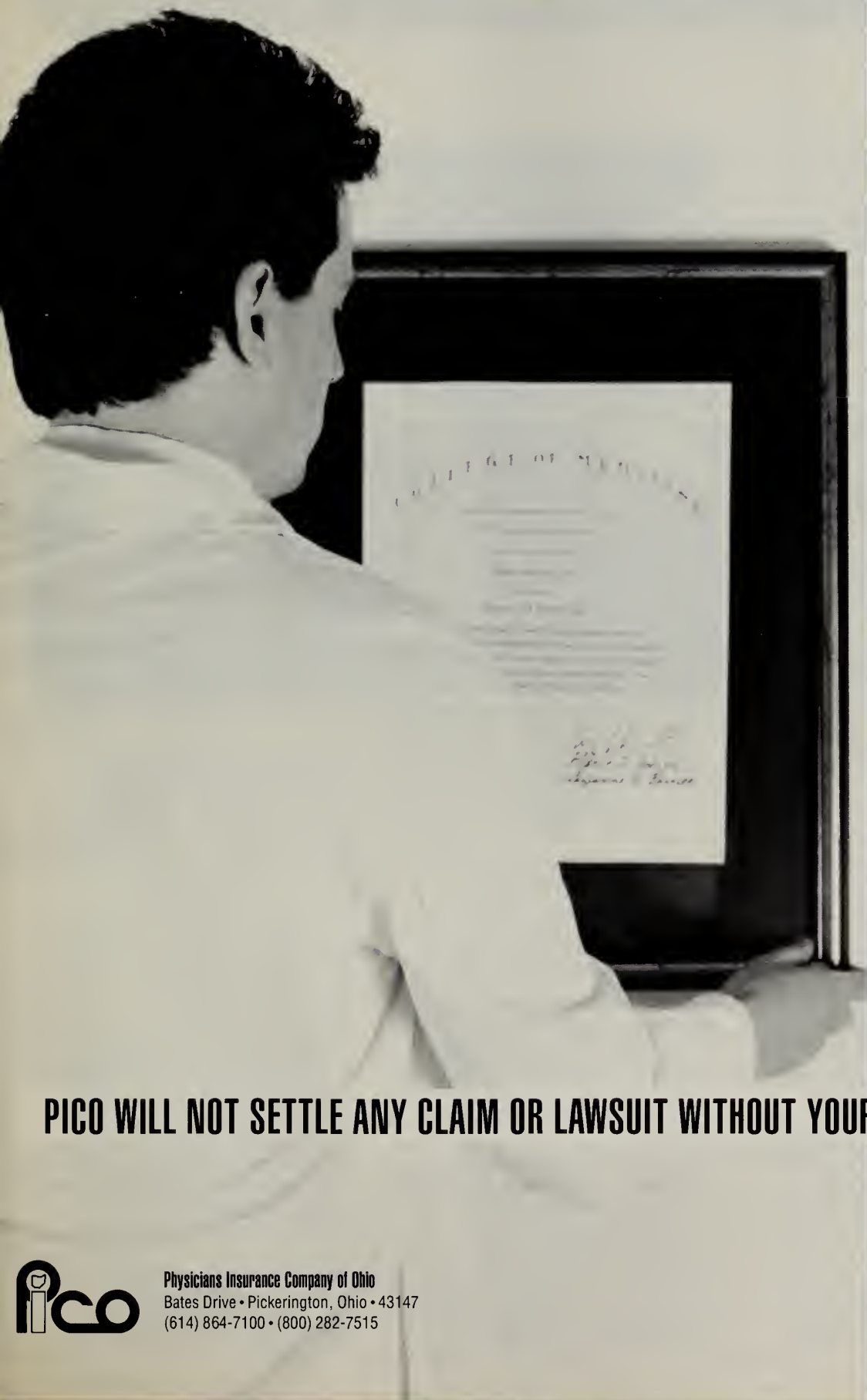
JAMES KELLEY SMITH, MD,
Golden, CO; Howard University College of Medicine, Washington, D.C., 1932; age 86; died August 20, 1991; member OSMa and AMA.

HENRY L. STROHMEYER, MD,
Dayton; Ohio State University College of Medicine, 1926; age 89; died August 18, 1991; member OSMa and AMA.

WILLIAM WALLBANK, MD,
Toledo; Harvard Medical School, Boston, MA, 1935; age 81; died August 25, 1991; member OSMa and AMA.

DAVID M. WAPPNER, MD,
Medina; Case Western Reserve University School of Medicine, 1960; age 60; died April 1991; member OSMa.

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Pathologists battle Blue Cross

They don't give up easily, these pathologists from Toledo and northwest Ohio. When Blue Cross and Blue Shield of Ohio arbitrarily halted reimbursement for some of their fees last year, about 25 of them took their case to the Ohio Department of Insurance, and then to the courts.

They've been beset by frustration each step of the way. But the case has given them the opportunity to place the controversy squarely before the public.

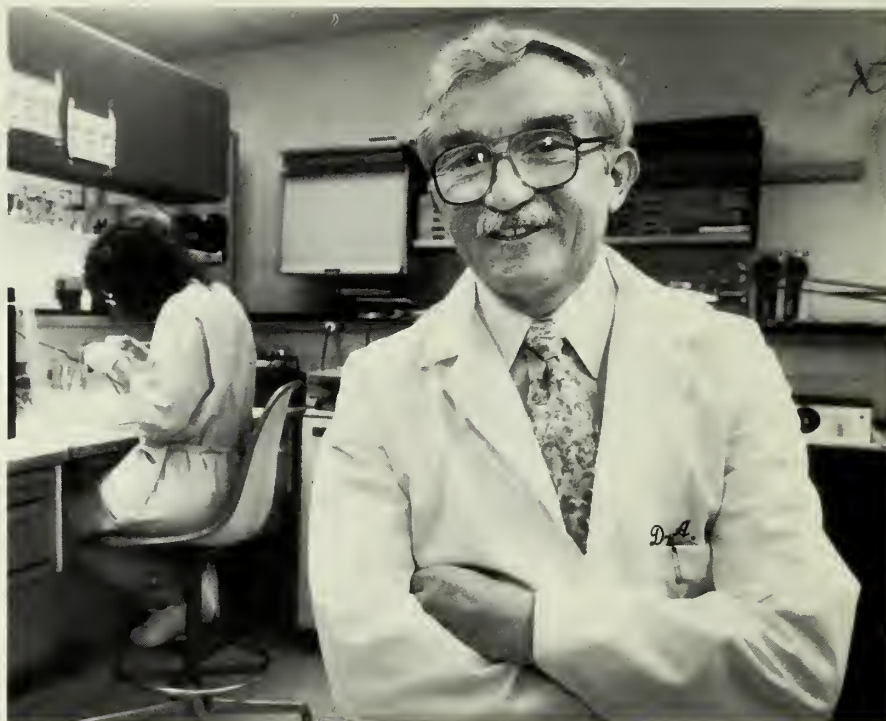
Blue Cross "has maligned the professional integrity of physicians and impaired their ability to be compensated for services rendered," their attorney argued in Franklin County (Columbus) Court of Appeals September 11.

The case stems from Blue Cross' denial, beginning in January last year, of reimbursement for the professional component of clinical pathology.

The professional component is a small fee assessed on each laboratory service to reimburse the pathologist for supervising the laboratory. This supervision includes quality assurance, determining reference values, educating the hospital medical staff, and other physician services required by the JCAHO, Medicare and other insurers. The professional component also reimburses the pathologist for the legal, professional and budgetary responsibility he or she assumes for supervising the laboratory.

Blue Cross had reimbursed pathologists for the professional component since 1966.

"Blue Cross paid for these services for decades," said Dr. Alcuin D. Bennett, a pathologist and president-elect of the Toledo



Alcuin D. Bennett, MD, pathologist and president-elect of the Toledo and Lucas County Academy of Medicine

and Lucas County Academy of Medicine. "Now they describe them as 'not medically necessary.' "

California pathologists are fighting a similar battle. The California Society of Pathologists filed suit in July against Blue Cross of California on behalf of Blue Cross policyholders. The suit contends that, since pathologists will not perform work for which they are not paid, policyholders will likely not get the laboratory services to which they are entitled. No ruling has been issued yet in this case.

The battle in both states does not apply to anatomical pathology, and salaried pathologists are generally not affected.

In their complaint filed in July last year with the insurance department, the pathologists noted that Blue Cross contracts with policyholders do not exclude

reimbursement for the professional component of clinical laboratory services. The pathologists also complained that some statements made to subscribers by Blue Cross were false and misleading.

But the insurance department refused to hold a hearing, as the pathologists requested. The department said the Blue Cross denial of reimbursement was not a reduction in benefits to subscribers, but a modification of payment protocol to pathologists. The department failed to address the issue of whether Blue Cross had made false and misleading statements.

The pathologists appealed to the Franklin County Court of Common Pleas, which declined to support them, ruling that the matter was within the jurisdiction of the insurance department.

So the pathologists appealed that decision to the court of

Legal

appeals. In the oral arguments September 11, both sides presented their points of view before a three-judge panel. A decision may not come until early next year. **OSMA**

Without cap on malpractice awards, will premiums increase?

If physicians see their liability premiums increased over the next few years, malpractice insurance carriers say it won't necessarily be due to the Ohio Supreme Court's recent decision to lift the \$200,000 damages cap on malpractice awards.

"It's been our experience that the courts, by and large, have ignored the caps, so there is no reason for the Supreme Court decision to have any effect on premium rates," says Mark Hannan, vice-president of Operations for the Physicians Insurance Company of Ohio.

William Ludwig, senior vice-president for Claims at Physicians Insurance Exchange, agrees that the courts in northern Ohio have ignored caps on damage awards for years, but says courts in southern Ohio have traditionally taken a more conservative approach to interpreting the law and have generally upheld the cap. However, he's hesitant to say whether or not this dichotomy will have an effect on subscriber premiums.

"Premiums are driven by loss experiences and affected by the legal climate," Ludwig says. "It's debatable whether or not the cap

really had an impact, but if awards suddenly become more ludicrous and we discover the cap really *had* been enforced, then, yes, it could have an impact on rates."

Robert Miller, vice-president of Consumer Affairs and Risk Management at Medical Protective Company, is more certain, however, that the potential for unlimited damage awards will produce higher premiums.

"There will be no immediate, automatic effect," he says, "but there is no question that premiums will eventually be affected by the decision."

He points to Indiana where, two years ago, the cap on malpractice awards was raised from \$500,000 to \$750,000. Physicians there, he says, have seen the surcharge on their basic premium coverage raised from 125% to 150%.

"Rates have been affected in other states, whether the cap was lifted, raised or placed on awards," Miller continues. He predicts that, as early as next year, policyholders may see some increase on their policies as they come up for renewal.

Other carriers, however, say that any premium increases their subscribers may see over the next few years are as likely to be due to *other* factors and trends as to Ohio's Supreme Court decision.

"We've noticed in just the last year or two an increase in the number of malpractice claims," says Barry Johnson, spokesperson for St. Paul's Insurance Company. "The fact that the cap was struck down by the court is not really a major concern for us. Of course, the decision will have to be factored into the rate-making process, but it will be hard to say whether an increase in premiums will be the result of the elimination of the cap, or the increase in claims."

Ludwig of PIE says that his

company has also noticed a sharp rise in the severity of claims over the last few years, and that on its own has already created the potential for higher rates. The lack of a cap on damage awards, however, may aggravate that situation even further.

"A cap can stabilize rates," Ludwig says.

Without a cap, he continues, predictability becomes non-existent. The settlement of *all* cases, then, is jeopardized by this potential for a runaway verdict.

Ludwig says he is also concerned that the Ohio Supreme Court decision seems to have eliminated the court's reluctance to interfere with any passion and prejudice verdict a jury might hand down.

"A jury can award \$12 million in one case, and \$500,000 in a similar one, and both would be considered reasonable by the courts," he says.

If there was anything positive in the Supreme Court's decision, it was in the court's willingness to uphold the collateral payments provision of the 1975 Ohio Medical Malpractice Act, says PICO's Hannan.

"The fact that any payment the plaintiff has received from workers' compensation programs, automobile insurance companies, and so on can still be *subtracted* from the final judgment has a far greater impact than does lifting the cap," he says.

Still, PIE's Ludwig points out that the insurance industry needs caps to prevent insurance rates from becoming unstable.

"If caps are reintroduced in the state legislature, physicians as well as insurance companies need to support them," he says.

He notes, however, that any state legislative efforts to establish caps may be unnecessary.

"There are already two bills on this issue pending in the U.S.

Legal

Congress," says Ludwig. "If the states won't set caps on malpractice awards, maybe the federal government will." **OSMA**

Summit County police expand drug-testing program

As Summit County physicians await the Ohio Supreme Court's decision on the legalities of a prescription drug tracking program, the program has been expanded to four other communities, bringing the total number of those involved to 10. They are: Stow, Hudson, Hudson Township, Munroe Falls, Tallmadge, Mogadore, Twinsburg, Macedonia, Streetsboro and Kent.

Both Common Pleas Court and the Ohio Court of Appeals have upheld the legality of the program so far.

"If they suspect a person, I see no problem with it," Robert Casto, MD, president of the Summit County Medical Society, has said in news reports. However, the suit, filed by the Summit County physicians and supported by both the Summit County Medical Society and the OSMA, is not meant to keep the police from doing their duty, but to make sure prescription drug tracking is not abused for other purposes, Dr. Casto says.

Police currently monitor prescriptions filled for the painkillers Percodan, Dilaudid, Tylox and Zanax, and amphetamines Apidex and Ritalin. According to Akron Police Department's Narcotics Division,



Dilaudid has a street value of \$40-\$50 per tablet and Percodan and Tylox both sell for \$10 a pill on the street. Police add that they are only looking for drugs prescribed in large enough quantities to arouse suspicion. **OSMA**

U.S. Attorney cracks down on Ohio health-care fraud

U.S. Attorney D. Michael Crites has recently formed a task force that intends to crack down on health insurance and Medicare fraud in southern Ohio.

The task force includes representatives from the FBI, the U.S. Department of Health and Human Services, the U.S. Postal Service, the Defense Criminal Investigative Service and other federal agencies. Its responsibility, says Crites, will be to launch criminal investigations and "target unscrupulous health-care providers who engage in fraud for their own personal gain."

Although Crites adds that the overwhelming majority of health-care providers are honorable professionals, recent alleged fraud

cases "show the need for more enforcement."

"We don't have to go out and look for cases," he argues. "There are a number of cases already under investigation."

The General Accounting Office has estimated that fraud accounts for 10% of the total monies spent each year for Medicare and Medicaid — a figure that's disputed by the AMA. Yet, the Department of Health and Human Services set up a toll-free fraud hot-line not long ago to facilitate patients, health-care workers and other "whistleblowers" who wish to report cases of suspected abuse. Those who aren't driven to report by civic duty may be enticed by a federal law that allows reporting parties to recover a portion of any damages owed the government as the result of a fraud finding.

Crites says he hopes publicity for the hot-line will net new information for task force members to investigate.

OHIO Medicine will keep you posted on further task force developments as they occur. **OSMA**.

TASK FORCE'S FOCUS

U.S. Attorney D. Michael Crites said the task force will focus on fraud cases that are often difficult to detect such as billing:

- **Health insurance** carriers twice for the same service.
- **For unperformed** or unnecessary services.
- **Medicare patients** at a higher reimbursement rate than for non-Medicare patients.
- **For unallowable** services by disguising the service as allowable.
- **For brand name** drugs when generic brands were actually used.
- **Christmas parties** as mental health services.

Legal

The Law and Your Practice

Saying goodbye to your patients

Suppose you decide to move out of state . . . or retire . . . or simply decide that it is impossible for you to treat Mr. Jones anymore because he never follows your treatment schedule. How do you *legally* tell your patients goodbye?

"The patient should be notified, in writing, that you are withdrawing your services as his or her physician," says Scott Clapp, OSMA's associate legal counsel.

Write a letter, notifying the patient that you are discontinuing your services. You need not state a reason (although it's always better public relations if you do), but you *must* give the patient reasonable time to locate another physician to take your place.

"Reasonable" time is somewhat awkward to define, however.

"It can vary by location, specialty and circumstances," says Clapp.

Generally, a minimum of 30 days is considered a reasonable time for a patient to locate another physician. However, if you're the only neurosurgeon practicing in a small community in southeastern Ohio, for example, reasonable time might have to be extended beyond the 30 days. Probably the best way to determine a reasonable amount of time is to consult other physicians in the area. Factor in the condition of the patient and the availability of other physicians in your specialty in the area, and you should have a good idea of how much time to allow.

Until the patient has had reasonable time to locate another physician, remember, you are still obligated to treat that patient each time he or she shows up in your office, up until the date you have specified as your termination date in your letter to the patient. If you fail to do so, or if proper notice is not given and the patient suffers damages, your patients may allege abandonment.

As far as the patient's medical records are concerned, Clapp says that physicians should keep the patient's original records and transfer copies of the records to the patient's new physician. You may charge a reasonable fee that reflects your costs for making the copies.

If you are retiring from practice, you should read the article that appeared in the February 1991 issue of *OHIO Medicine*, "Medical Records Must Go With You," although it's worth clarifying, at this time, a point in that article that may have been misunderstood.

The article may have given the impression that medical records cannot be transferred to the physician purchasing the practice. In fact, records *can* be transferred to the buyer. However, until the patient agrees to transfer his or her care to the purchasing physician, the physician who receives the transferred records does not have the same rights of access to the information in the records as the selling physician. The records are still the property of the selling physician. Until the patient transfers care to the purchasing physician, the physician acts simply as custodian of the records. In any case, the selling physician should guarantee his or her right to access the records to defend against a malpractice action. The best way to guarantee access is to

provide for it in the contract to sell the practice.

Recently, a situation in South Carolina created a brand-new twist in the area of selling or transferring patient records. A physician, moving out of state, sold his office building at auction to a business executive. As part of the deal, the executive also bought the patients' records.

Physicians who make this kind of deal may be stepping into some very hot legal water — never mind the ethical problems that arise, especially if the physician happens to be a psychiatrist, or works at a clinic that treats sexually transmitted diseases or treats AIDS patients.

In Ohio, although no law expressly forbids the selling of patient records to those outside the medical profession, by doing so, the physician may risk violating two Ohio statutes:

- 1.) Willfully betraying a patient's confidence. ORC 4731.22 (B)(4) and
- 2.) Violating any provision of a code of ethics ORC 4731.22 (B)(18), if the buyer can and does access information in those records.

"I'd also think it likely that the physician might be sued for malpractice if the buyer does access that information and the patient suffers damages," says Clapp.

The moral here is that when you leave the practice of medicine, responsibility to protect the confidence of your patients continues. **OSMA**

Bigger crackdown due on pharmaceutical seminars

The Food and Drug Administration intends to crack down even harder on promotional abuses in the pharmaceutical industry — and doctors are one of the key groups on which the agency will focus.

David Kessler, the FDA's new commissioner, said that doctors who serve as company-paid experts at industry-sponsored symposia or other events will be subject to civil sanctions or criminal prosecution if the agency determines the events themselves amount to illegal promotion of prescription drugs.

The FDA is developing guidelines on what sorts of promotional activities are appropriate, but they haven't yet been published — and until they are, the pharmaceutical industry is taking steps not only to reduce the number of symposia it presents, but to hold those symposia in less exotic locales as well.

Meanwhile, Kessler has indicated that appropriate symposia include those where sponsors have neither express nor implied control over the scientific content of the program, and where experts representing a diversity of legitimate medical opinion are included in a program. Doctors are advised, he says, to turn down projects where industry representatives pressure them to present data in a biased manner, and to avoid programs that emphasize recreational events.

He urges physicians to confine their participation to those activities presented in conjunction with a respected and planned scientific meeting. "Sponsors of such seminars should be clearly disclosed, and any financial relationships between a sponsor

and participating doctor should be disclosed," he adds.

The FDA lacks the authority to regulate doctors, so any enforcement efforts the agency makes will be aimed only at physicians who disseminate information as agents of companies.

Both the AMA and the Pharmaceutical Manufacturers Association have adopted a set of guidelines, aimed at reducing the potential for abusive use of industry promoting. Those guidelines appeared in the April, 1991 issue of *OHIO Medicine*.

Meanwhile, Gail Dodson, director of OSMA's Department of Administrative and Education Services, reports that the association's Committee on Accreditation is making sure that each facility it accredits receives a set of guidelines for commercial support of CME, prepared by the national Accreditation Council for Continuing Medical Education. (See sidebar.)

"The OSMA no longer provides a scientific meeting," she says, "but if we did, we would follow the ACCME guidelines in setting up any programs sponsored by pharmaceutical manufacturers."

OSMA

Guidelines for commercial support of continuing medical education

Preamble

The purpose of continuing medical education (CME) is to enhance the physician's ability to care for patients. It is the responsibility of the accredited sponsor of a CME activity to assure that the activity is designed primarily for that purpose.

Accredited sponsors often receive financial and other support from non-accredited commercial organizations. Such support can contribute significantly to the quality of CME activities. The purpose of these guidelines is to describe appropriate behavior of accredited sponsors in planning, designing, implementing and evaluating certified CME activities for which commercial support is received.

Guidelines

1. Accredited sponsors are responsible for the content, quality and scientific integrity of all CME activities certified for credit. Identification of continuing medical education needs, determination of educational objectives, and selection of content, faculty, educational methods and materials is the responsibility of the accredited sponsor. Similarly, evaluation must be designed and performed by the accredited sponsor.
2. The accredited sponsor is responsible for the quality, content and use of enduring materials for purposes of CME credit. (For the definition, see ACCME "Guidelines for Enduring Materials.")
3. Presentations must give a

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balanced view of all therapeutic options. Use of generic names will contribute to this impartiality. If trade names are used, those of several companies should be used rather than only that of a single sponsoring company.

4. When commercial exhibits are part of the overall program, arrangements for these should not influence planning nor interfere with the presentation of CME activities. Exhibit placement should not be a condition of support for a CME activity.
5. The ultimate decision regarding funding arrangements for CME activities must be the responsibility of the accredited sponsor. Funds from a commercial source should be in the form of an educational grant made payable to the accredited sponsor for the support of programming. However, all support in relation to the certified CME activity must be made with the full knowledge and approval of the accredited sponsor. Payment of reasonable honoraria and reimbursement of out-of-pocket expenses for faculty is customary and proper. Commercial support must be acknowledged in printed announcements and brochures, however reference must not be made to specific products. Following the CME activity, upon request, the accredited sponsor should be prepared to report to each commercial supporter and other relevant parties, and each commercial supporter to the accredited sponsor, information concerning the expenditures of funds each has provided.
6. Commercially supported social events at CME activities should not compete with, nor take

precedence over, the educational events.

7. An accredited sponsor shall have a policy on conflict of interest applicable to CME activities. All certified CME activities shall conform to this policy.
8. In an activity offered by an accredited sponsor it is not permissible to provide for travel, lodging, honoraria or personal expenses for attendees. Subsidies for hospitality should not be provided outside of modest meals or social events that are held as a part of the activity. Scholarship or other special funding to permit medical students, residents or fellows to attend selected educational

conferences may be provided, as long as the selection of students, residents or fellows who will receive the funds is made either by the academic or training institution or by the accredited sponsor with the full concurrence of the academic or training institution. **OSMA**

HEALTH CARE LAW

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Renoir's Maladies: The Medical Tribulations of an Impressionist

James G. Ravin, MD

The paintings of Pierre-Auguste Renoir are works of sensual pleasure, not of the

intellect. In describing his efforts, Renoir said, "When I look at the old masters I feel a simple little man, yet I believe that among my works there will be enough to assure me a place in the French School, that school which I love so much, which is so pretty, so clear, such good company."¹

There is no doubt that he succeeded. Renoir is of interest medically. His health was

adversely affected by a severely disabling case of rheumatoid arthritis, and alterations in his eyesight may have affected his

artistic production.

Renoir's Themes

Landscape was an important subject for Renoir, although it was usually secondary to the human figure. One fine example of pure landscape is "Road at Wargemont." Painted in 1879, it depicts a twisted road curving through the Normandy countryside without any special feature to attract the viewer's attention. It was painted rapidly in thin oil paint. One critic has called this Renoir's greatest landscape, and said it was his favorite painting in the major retrospective given the artist in London, Paris, and Boston in 1985 and 1986.² He described the composition further, saying "a high vantage point gives onto a complex network of sinuously curving slopes, paths and rows of trees by which the eye is carried simultaneously across the picture surface and back into space, past nodal junctures that offer a maze of alternative routes, finally arriving at a distant horizon that itself pulses rhythmically with the suggestion of



*The Green Jardiniere. Renoir
Courtesy Toledo Museum of Art*

Art and Culture

hidden energies.”

The human figure was an important theme for Renoir. In his own words, Renoir described his goal: “I’m trying to fuse the landscape with my fingers. The old masters never attempted this.”³ He altered the appearance of his models and their backgrounds in creating this fusion. He took liberty with the proportions of his models, often making them more full bodied and round than in real life, so that at least one model had difficulty in recognizing herself in the painted version. Renoir consciously emulated two old masters, Titian and Rubens, employing their monumental, curvaceous ideals of feminine beauty. In turn Renoir’s body types become an important influence on Picasso.

Renoir’s Health

The first notable medical event to affect Renoir’s method of work was a bicycle accident in 1880. He broke his right arm, but being ambidextrous, began to paint with the opposite arm. In a letter he treated this jocularly: “I am enjoying working with my left hand, it is very amusing and it’s even better than what I would do with the right. I think it was a good thing to have broken my arm, it made me make some progress.”⁴

In December 1888, Renoir was afflicted with his first serious bout of rheumatoid arthritis, the illness that was to cause him so much grief in the years to come. In addition to the arthritis, he had problems with his eyes, ears and teeth at that time.

Rheumatoid arthritis caused him massive deformities of multiple joints and produced a reduction in his ability to use his hands. Many photographs of the artist during

his last decades of life reveal this. Motion pictures of Renoir painting exist, and even if we take into account the jerky motions of early cinematography, he is seen jabbing at the canvas, rather than painting with a smooth motion. The arthritis reduced his manual dexterity. He lost the ability to make fine motions with his fingertips, and tended to move the brush with his forearms and arm, which caused broader and less detailed depiction of forms. One biographer thinks that this had a great impact on the evolution of his style: “Because of his illness, Renoir was never able to regain the heights of genius, diversity, and innovation apparent in his greatest paintings of 1872 through 1883. Nonetheless, despite what could have been regarded as a devastating incapacity, the heroic Renoir was able to cope with and transcend his illness by sustained creative work. In this light, the paintings of his last 30 years are courageous and, toward the end, miraculous.”⁶

As his arthritis worsened, Renoir found the extremes of temperature in Paris more and more uncomfortable, and he spent more time in the south of France. To others, he appeared timid and frail. In 1897 he had another bicycle accident, refracturing his right arm. As in 1880, he turned to painting with his left arm. Pissarro, the elder statesman of French Impressionism, complemented him in saying “Didn’t Renoir, when he broke his right arm, do some ravishing paintings with his left hand?”⁷

Julie Manet frequently visited Renoir and wrote “Renoir’s health changes every day, sometimes he looks fine, but then his feet and hands swell; this disease is really very annoying, and he, so nervous,

puts up with it with a lot of patience . . . It is so painful to see him in the morning not having the strength to turn a doorknob.”⁸

Medical treatment for Renoir’s arthritis included oral antipyrine (an anti-inflammatory drug similar to aspirin), sunshine, walks, massage, baths, purges, application of heat, and visits to spas such as Aix-les-Bains. A surgeon frequently scraped at his rheumatoid nodules. Despite a good appetite he lost weight, being only 97 pounds in 1904. He used a cane, but later had to be transported in a wheelchair or portable chair. His son Jean described his appearance at age 70: “What struck outsiders coming into his presence for the first time were his eyes and hands. His eyes were light brown, verging on yellow. His eyesight was very keen. Often he would point out to us on the horizon a bird of prey flying over the valley . . . As for their expression, imagine a mixture of irony and tenderness, of joking and sensuality . . . His hands were terribly deformed. Rheumatism had cracked the joints, bending the thumb toward the palm and the other fingers toward the wrist. Visitors who weren’t used to it couldn’t take their eyes off this mutilation. Their reaction, which they didn’t dare express, was: ‘It’s not possible. With those hands, he can’t paint these pictures.’”⁹ He became unable to pick up objects. Photographs show linen strips or bandages in an x-shaped pattern over his hands, which have been misinterpreted as straps to hold the brush in his hands. Actually the cloth served as a dressing to protect his fragile skin from damage by the wooden brush. He became unable to change brushes, and an assistant did this for him.

In 1912 he suffered a stroke, but

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recovered within a few months. During his last few years, arthritis crippled him so badly that he remained in his room for weeks at a time. Although extremely thin and severely arthritic, he painted up until his death at age 78 in 1919.

Age-Related Stylistic Changes

In his late works Renoir changed his style, painting with less detail and with a marked preponderance of warm, rich, red tones. He was working in the warm sunlight of southern France at the time, and preferred to use warm colors so that if they darkened with time, the warmth would still be apparent.³

It is possible that these changes are due in part to alterations in his eyesight. Our ability to see details and perceive color changes with age.

Renoir's canvases reveal a change from a wide range of hues in his early works to late paintings in which reds predominate. Similar changes in details and colors with advancing age are found in the works of other artists, notably Titian, Constable, Rembrandt and Rouault.^{10,11} Changes in color perception can be explained by the fact that the ocular media, especially the lens, act as a yellow filter to block transmission of some light rays on their way to the retina. The result is that a disproportionate amount of violet, blue, and green light rays are filtered out, while red and brown are relatively unaffected.

Myopia or Presbyopia?

Was Renoir nearsighted? Trevor-Roper, in *The World Through Blunted Sight*¹² says yes, but I have not been able to confirm this in any other reference to the artist. Trevor-Roper wrote "Renoir, who, according to his biographer

Vollard, when looking at pictures would step back a few paces [in other words out of his limited near-range of clear vision] in order

to give it the effect of an Impressionistic picture." Of course, this statement does not prove Renoir was myopic. It indicates he

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Art and Culture

liked to look at his paintings from a certain distance, just as many myopic as well as nonmyopic artists often do. Trevor-Roper continues "He was then 60; and even at 64, when none of us who are not myopic can expect to read at near range without convex spectacles, he like to examine petit-point close to, taking it in his hands." This misinterprets Vollard, for Vollard was not referring to a form of embroidery, but to pointillism, the method of painting devised by Seurat to cover the canvas in small spots of color. Trevor-Roper next says "We know he wore no glasses: he is said to have waved them away the remark, 'Bon Dieu, je vois comme Bouguereau.' " I have tried, without success, to find another reference to this quotation of seeing like Buguereau, that Renoir saw the world with too much detail.

A recent biography of Renoir warns us to be very careful in evaluating memoirs written long after the fact, that depend on distant memory: "After the artist's death, many of his friends and his son Jean wrote colorful, anecdotal accounts of his life and art."¹³ Nevertheless, I feel that Jean Renoir's comments about his father's eyesight are important. He wrote that his father's vision remained keen up to his death, and "I can still see him applying a point of white, no larger than a pinhead, to his canvas to indicate a reflection in the eye of a model . . . We had to use a magnifying glass to make out the details of the perfect likeness. He sometimes wore glasses for reading, but he did so chiefly to save his eyes. When he was in a hurry or whenever he mislaid his glasses, he managed quite well without them. Whenever the weather permitted, we liked to sit

on the terrace in the evening and watch the fishermen at Cros-de-Cagnes sailing back to port. My father was always the first to spot a boat."¹⁴

The most reasonable conclusion is to discount the anecdotes about Renoir's alleged myopia, and to accept Jean Renoir's account of his father's presbyopia. **OSMA**

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James G. Ravin, MD is chair of Art and Culture Committee.

Second Opinion

continued . . .

the downfall of only one player in this multitude of cascading events that causes a quality of care concern."

The physician is not the only player in the quality of care game, but still physicians continue to bear a disproportionate share of the liability. Physicians — not hospitals — are the ones who acquire the "quality point profiling" administered by HCFA's Quality Intervention program. But shouldn't this same "point system" — which triggers intervention with physicians — be applied equally to hospitals when errors are identified? I believe the time has come for quality assurance committees to begin to identify and document hospital errors so that hospitals can also be sanctioned with a quality intervention program "point system."

Hospitals are part of the health-care team. They must start to pull their own load, assume their proportionate liability and be monitored by quality assurance committees. In the future, I believe medical staffs will expect it. **OSMA**

Emerson Laird, MD, practices internal medicine in Mt. Vernon.

**The AMA
Hospital Medical Staff Section
Eighteenth Assembly Meeting
December 5 - 9, 1991
Las Vegas Hilton Hotel
Las Vegas, Nevada**

Highlights of the Interim Meeting will include:

- an educational program on RBRVS: Physician Payment Reform or Retribution;
- presentation by the AMA-HMSS Governing Council of reports on medical staff issues including temporary Hospital Medical Staff Privileges, Joint Commission Revisions for the 1992 Accreditation Manual for Hospitals; and Advance Directives;
- an information exchange on PRO Scope of Work and Uniform Clinical Data Sets: What You Should Know.

For Information Contact:

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Chicago, Illinois 60610
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HMSS

Science and Education

Ohio Cancer Information Service: A Decade of Experience

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Department of Preventive Medicine

Comprehensive Cancer Center — Arthur G. James
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The Ohio Cancer Information Service (OCIS) utilizes a public toll-free telephone number (1-800-4-CANCER) to provide rapid access to cancer information for all Ohioans. This outreach service is the Ohio arm of the nationwide network of Cancer Information Service (CIS) offices supported by the National Cancer Institute (NCI). Since its inception in 1979 on a modest scale, the OCIS call volume has increased steadily, reflecting the growing public awareness of this service (Figure 1). Within a decade of operation, the OCIS has received more than 140,000 calls. The highest annual call volume of over 21,000 occurred in 1990.

Program objectives

The telephone has proven to be a valuable tool for information transfer and crisis intervention, and the OCIS is effectively utilizing this tool for public service in cancer information transfer and dissemination. Our primary goal is to provide the public and health professionals quick and easy access to the latest and most accurate information on the prevention, early detection, treatment and rehabilitation of all forms of cancer.



Touring the new center

Gary Krantz (right), incoming chair of the Franklin County Unit of the American Cancer Society, joins Arthur James, MD, and Nancy J. Davis, administrator for Nursing for the Arthur G. James Cancer Hospital and Research Institute in Columbus, in touring the new Babe Zaharias Women's Cancer Center at the hospital. The center will provide both screening and diagnostic services.

OCIS operations

The 1-800-4-CANCER toll-free OCIS phone lines are manned by trained professionals. Appropriate procedures are implemented to ensure quality of responses and disclaimers. Besides counseling, free NCI-printed materials on cancer (warning signals, detection, treatment and resources) are forwarded to callers on request. The PDQ and other computer sources on cancer information, treatment protocols, physician resources and health-care organizations are utilized to provide appropriate responses to complex queries.

The CIS is publicized nationally through electronic and print media. In addition, a variety of state and local promotional

schema have been used by the OCIS, eg. local media events, state and county health fairs, professional conferences, local hospital programs and other public events.

Call profile

Calls are received from all 88 counties in Ohio. However, the callers are not a representative sample of the Ohio general population. Callers are mostly female (74%), older (31% over 50), and better educated (44% finished high school) than the general Ohio population. In 1990, 42% of calls were from the general public, 20% from cancer patients, and 26% from relatives and friends of patients. Only 4% of calls were from health professionals, which is

Science and Education

significantly lower ($p < 0.05$) than the national rate of 7%.

Topic of inquiry

Most callers inquire about treatment and/or rehabilitation (41%). Notably, the number of callers referred to NCI-approved clinical trials increased from 1,017 to 1,464 (44%) during the past year. Other major topics of inquiry include cancer prevention (31%), screening and early detection (16%), and requests for literature (12%). The topic of inquiry varies with the type of caller. Subjects from the general public are more interested in cancer prevention, whereas patients and relatives seek information about treatment and resources. More younger callers inquire about smoking and cancer, whereas older callers ask about diet and cancer.

About 30% of the callers seek site-specific cancer information. Among these site-specific inquiries, the distribution of cancer sites reflects the distribution of the major cancers in Ohio, eg. breast cancer (24%), lung cancer (13%), colon cancer (12%), prostate cancer (10%), and hematopoietic cancers (10%).

Caller satisfaction

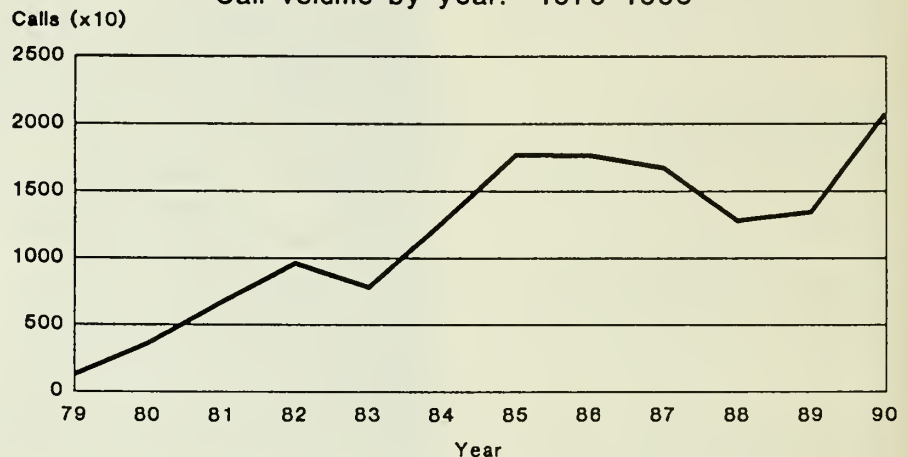
Periodic NCI surveys reveal high (99%) caller satisfaction with OCIS. Nearly 18% of the callers had previously used the service. Among new callers, about 25% learned about OCIS through public service announcements on TV and radio whereas over 40% were introduced through printed media or other literature. Only 1% of Ohio callers learned about OCIS from health professionals, which is low compared to the national rate of 3%.

Comment

The telephone has proven to be

Figure 1. Ohio Cancer Information Service

Call volume by year: 1979-1990



a valuable tool for information transfer and crisis intervention and the OCIS is effectively utilizing this tool for public service in cancer information transfer and dissemination. Feedback received from users confirms that the OCIS is providing an educational support mechanism for cancer patients and their families, as well as linking callers with regional resources for the early detection, treatment and rehabilitation of cancer. In addition, OCIS serves as a mechanism to heighten cancer risk awareness in the general public and provides incentives to adopt risk reduction measures. Greater utilization of the OCIS by men, physicians, rural residents, those with lower levels of education and minorities is desired. These groups either are less aware of OCIS or are not in the habit of using the telephone as an informational tool. Special promotional efforts are being explored and implemented to effectively reach these groups and widen the impact of this service.

Our goal is to provide accurate cancer information and help assure access to state-of-the-science preventive, diagnostic, therapeutic and rehabilitative cancer care for all socioeconomic and cultural groups. **OSMA**

Reference

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Acknowledgment

We acknowledge past and present staff of the Cancer Information Service and all members of our External Advisory Board. This work was supported by National Cancer Institute contract N01-CO-03873.

Science and Education

CDC calls for AIDS testing for hospital patients

This month, a final version of a recommendation calling for widespread AIDS testing of hospital patients is expected to be issued by the Centers for Disease Control.

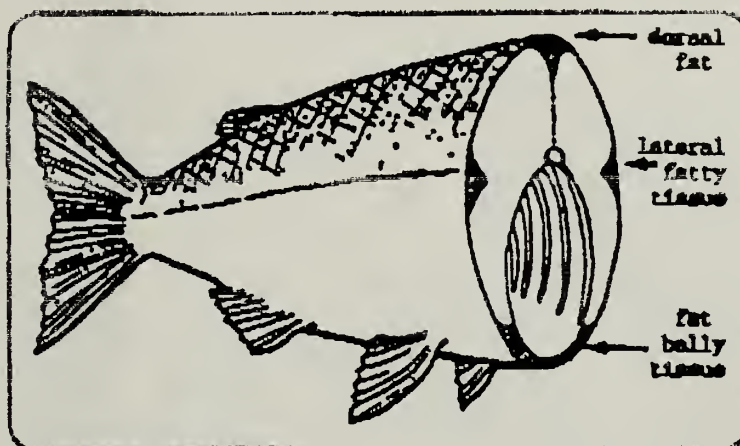
The recommendation that appeared in a draft report earlier this fall proposes that medical hospitals "routinely offer and encourage" tests for HIV. Such tests would have to be made with the patient's consent, and the results provided to them in confidence.

The draft report fueled new debate in the merits of AIDS testing, but CDC director William L. Roper, MD defended the report, saying it's to anyone's benefit to know if they test positive. "They can be counseled about their behavior and avoid exposing others," he says. Dr. Roper also points out that if someone needs to be treated for another illness, the attending physician needs to know whether or not the patient's immune system is working.

The CDC is not recommending AIDS testing for the public at large, and its policy would not be binding.

"If you've got a hospital treating mostly Medicare patients in North Dakota, it's likely (to be) not worthwhile to do routine testing of all admissions," Dr. Roper says.

Critics, however, say that testing of hospital patients without guarantees of counseling, follow-up, early intervention and assurances against discrimination would mean people would stay away from necessary care. **OSMA**



Please don't eat the fish: Lake waters stir new controversy

The Great Lakes Science Advisory Board has raised new warning flags about Great Lakes toxins, arguing that strong evidence now shows that the contamination is causing a broad range of health problems in both animals and people.

Consequently, the board is asking the International Joint Commission to bump Great Lakes toxins from classification as a "human health threat" to "human health hazard," and is asking for a ban preventing six chemicals from being manufactured, used, stored, transported or disposed of in the Great Lakes basin. The substances are PCBs, DDT, dieldrin, toxaphene, mirex and hexachlorobenzene.

"Once released," the board report reads, "certain chemicals build to ever-higher levels in the food chain, making them more and more dangerous to wildlife and humans."

Physicians who aren't sure what advice to give patients (especially

pregnant patients) about eating Lake Erie fish might want to send for the fish and contact advisories that have been regularly distributed by the Ohio Department of Health since the 1980s.

Currently, ODH recommends that people avoid eating large carp and catfish from the Great Lakes, both of which are bottom-dwelling fish that have spent years feeding off sediments where contaminants tend to accumulate. Although the advisory says that health effects of eating contaminated fish are not completely known, it goes on to say that all contaminants are harmful in low levels if consumed on a regular basis, and that PCB, the substance that contaminates most Lake Erie fish, may affect the birthweight of babies and, later, the child's behavior if the mother ate contaminated fish while pregnant. PCBs and other chemicals have also been proven to cause cancer in animals.

"The only Lake Erie fish we advise against eating are carp and catfish," says ODH spokesperson Randy Hertzner. So far, no directives have been issued warning against consumption of popular lake fish such as perch or walleye.

Science and Education

However, the ODH advisory does include special instructions for those who eat lake fish.

"The fish should be fileted and all visible traces of fat removed," says Hertzner. That's because toxic chemicals tend to accumulate in fatty tissues. Other instructions issued by the ODH include:

1. Cleaning and trimming — Remove all of the skin; cut away the dark meat on top of the fish along the backbone; slice off the fat belly meat along the bottom of the fish; and cut away a V-shaped wedge along the lateral line on each side of whole fish, or on the skin side of each filet.

2. Bake, broil, grill or roast fish, don't microwave, fry or boil. Don't reuse fat or juices from the fish.

3. Don't eat the largest, oldest fish (lunkens). They've had time to store more toxins. **OSMA**

Pediatricians: Save your money

The bad news is the cost of the heredito-metabolic screening program for children has been increased from its present \$10 cost to \$24 or \$25.

The *good* news is that physicians need not purchase the new kits — a replacement kit will be mailed to physicians for each kit they purchased at the previous cost and submitted to the state health laboratory.

To obtain replacement kits at no charge, physicians must:

1. Submit a list of repeat kits used from their stock and include the

following information with each kit: child's name; date of birth; date of initial sample collected (from hospital, birthing center or local health department); and kit number.

2. Submit the list, with required information, to:
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PO Box 2568
Columbus, Ohio
43216-2568. **OSMA**

Ohio hospitals will test yew-derived drug

The University of Cincinnati Medical Center and Children's Hospital Medical Center of Cincinnati have won approval to use taxol, a new drug derived from boiling the reddish-brown bark of the Pacific yew, to treat women with ovarian cancer and children with leukemia.

The drug prevents cancer cells from dividing, and can also create a metabolic imbalance in the cell that destroys it.

Both hospitals are part of a multi-hospital research group, funded by the National Cancer Institute in Bethesda, Maryland. Other hospitals are working with taxol on colon, head and neck, and prostate cancers.

As taxol begins to gain acceptance as a cancer treatment, more ways to obtain yew bark are

needed. Consequently, an inventory of yew trees is now being conducted. Current estimates say yew bark could continue to be stripped from the trees at its current pace for five years.

However, because stripping the bark kills the yew, conservationists are working on a plan to save the species for future generations while still satisfying medical needs. The answer may lie in synthesizing the drug, although a successful synthesis has eluded researchers for at least a decade. Still, scientists will continue to try.

"The general feeling here is that (taxol) is the best new anti-cancer drug that's come along in the last 10 to 15 years," says Saul Schepartz, MD, a cancer specialist with the NCI. **OSMA**

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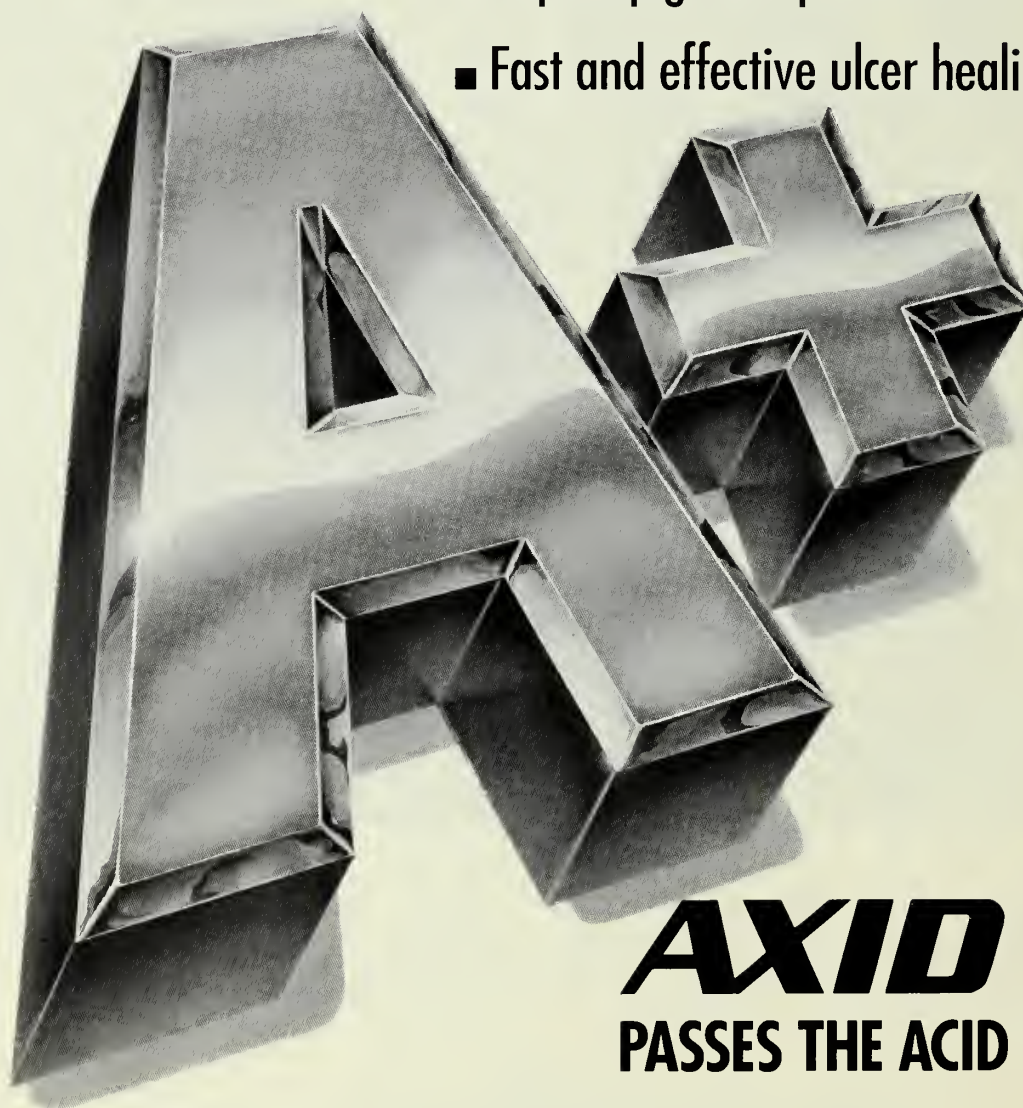
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Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

Contraindications: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, dislocated abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since marked introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage—Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

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2. *Scand J Gastroenterol* 1987;22(suppl 136):61-70
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Additional information available to the profession on request



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Medical Student Page

Who Do You Influence?

By Mary E. Chellis

One of my favorite movies is the classic called "It's a Wonderful Life." Every year at Christmas time I still enjoy watching Jimmy Stewart as George Bailey, battling the evil Mr. Potter, fixing little Zuzu's rose petals and desperately turning to Clarence, his guardian angel, for help in realizing how terrific his seemingly miserable life really is. Yet the one thing that particularly intrigues me about the film is the central theme that each one of us influences people in this world in important ways, ways in which we may never know. I've often wondered what this world would be like if I'd never lived in it.

Those of us in medicine are afforded a unique opportunity to not only have a tremendous effect on others lives, but to see how those lives can influence the rest of us. Certainly everybody has the chance to have an influence on others, but in medicine we can have the ultimate effect on people's lives. We have the chance to take a patient from serious illness to renewed health, to maintain his/her health and prevent disease, and in those for whom death is inevitable, we have the chance to make their remaining time comfortable and fulfilling. Equally important is the opportunity for us to witness what each individual means to those around him or her. When we pay

attention, we can see how patients influence this world in their own special ways.

Take, for example, a young boy I had the pleasure to meet during my third-year pediatrics rotation. I'll call him Joey. Joey suffered a traumatic birth that resulted in permanent quadriplegia, and has spent most of his eight years of his young life in the hospital. Since his family has all but abandoned him he relies upon people who are paid to feed, clothe and bathe him, to also entertain and care for him. These care-providers have educated and raised Joey, in addition to serving as his only source of emotional and moral support. Each day he watches as his condition further deteriorates, and suffers additionally with the respiratory problems that make him ventilator-dependent while he sleeps.

I'd heard Joey's story and decided that I felt sorry for him long before our first meeting. When I was introduced to him, I was surprised at what I found. I had expected to see his thinned arms and legs with their atrophied muscles from years of quiescent living, so I wasn't surprised by his limp, useless body slumped in a wheelchair; but I hadn't expected to see the huge grin that stretched from one ear to the next, and his bright cheerful eyes that actually sparkled behind the glasses he sported.

Continued on page 564

Medical Student . . . continued

During the next few weeks I saw Joey daily, and quickly learned the error of my hasty notion of pity for him. As I watched the nurses perform their daily tasks of percussing his chest, suctioning and changing his tracheostomy tube, adjusting his ventilator monitor, lifting and carrying him from bed to wheelchair, and from wheelchair back to bed, in addition to the endless attention he required, I realized that Joey never once complained nor bothered with feeling sorry for himself. He was too busy laughing and entertaining his foster family. I also realized that these people didn't do all of these things for Joey out of pity or duty, but out of love. He was their friend as well, and he made them feel happy and useful. If little Joey can make such a tremendous impression on his confined little world, just think of the influence we can have with all of our capabilities intact. The possibilities are endless!

Joey also serves as a reminder that each of our patients is a human being with a special value in this world. Even the most frustrating and difficult patients — the diabetic who won't take his insulin or those with emphysema who won't quit smoking — play a significant role in this world. And we have the opportunity to help them fulfill that role, whatever it may be. Many people would look at Joey and wonder why we continue paying for his expensive daily care when he is obviously giving nothing "useful" back to society. That's why we need to realize the importance of each and every person because each one has made an impression in this world of which we will never know the magnitude. And who can predict what the Joeys of this world will do in the future? While Joey will never work, he'll continue to make

Continued on page 565

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Medical Student . . . continued

people smile and perhaps help us to appreciate the little things we all take for granted.

A close friend of mine once told me, "There you are and have been, and influence in your little world, touching all kinds of people; in some cases, people you don't know of, people you have influenced of which 'works' you are unaware." God created each of us for a reason; to do a job designated for us, that no one else can do. We may never find out what our purpose here is, but it's there nonetheless. And so it is for every person we see. I suppose if we all had the chance to see what life would be like without us, we'd know the kind of mark we've made. But since we don't have that opportunity, we may as well believe that it's a wonderful life, and make the most of our abilities to influence this world. **OSMA**

Mary E. Chellis, Dayton, is a fourth-year medical student at Wright State University School of Medicine.

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Help needed for compulsive gamblers

Members of the Ohio Lottery Commission have asked the administration for more help for compulsive gamblers, speculating that their increased numbers may be due to the lottery and the opportunities it offers to place bets legally. James Mallory, the lottery's advocate for problem gamblers, says the lottery's hot-line to help gamblers is receiving 125-130 calls a month. Instant lottery may create most of the problems, says Mallory, because problem gamblers like the fast action the game provides. Surveys show less than 2% of lottery players have a gambling problem, but about 36% of problem gamblers play the lottery. At least 26 Ohio centers or hospitals currently offer outpatient programs to help compulsive gamblers. **OSMA**

Standardizing rape protocol

The Ohio Department of Health is testing a new Standardized Rape Protocol program in 90 hospitals to make emergency health-care providers more sensitive to the needs of rape victims. Two years in development, the 85-page rape protocol manual will be evaluated after the pilot project ends December 31, and revisions will be made if necessary. "Most states already have rape protocol

programs," says Judi Moseley, ODH coordinator for Women's Health and Rape Prevention. Standardized procedures called for in the new program include urging hospital emergency rooms to set aside a small room for rape victims, friends and family, and a step-by-step information sheet on how the victim will be dealt with before, during and after emergency room treatment. **OSMA**



Perinatal Projects gets national nod

Cuyahoga County's Perinatal Projects program was one of 12 singled out by the National Commission to Prevent Infant Mortality as models for the nation. The Perinatal Projects program has been credited with lowering the infant death rate between 21% and 42% in targeted neighborhoods by using trained volunteers to make home visits to pregnant women who are not receiving prenatal care. U.S. Surgeon General Antonia Novello says that success of home-visit programs, like the one in

Cuyahoga County, have been documented in numerous studies. "Most women really appreciate someone being interested in their situation," says the program's manager, Carol Rottman. "We have a method that works. Now, we are a leading voice in targeting infant mortality." **OSMA**

Suit filed over smoking ban

Ohio Legal Rights Service, on behalf of patients at Fallsview Psychiatric Hospital in Cuyahoga Falls, has filed a class action suit against the hospital and the director of the Ohio Department of Mental Health, which operates the hospital. The complaint stems from a smoking ban that was imposed on hospital patients in July 1990. Since that time, the hospital has had 10 fires, caused by surreptitious smoking. Both local and state fire marshals have asked hospital administrators to lift the ban, but, so far, they have not done so. According to the suit, staff members and visitors are allowed to smoke, so the ban violates patients' civil rights as well as state provisions for designated smoking areas in all state buildings. The case has been assigned and a hearing is pending. **OSMA**

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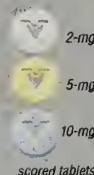
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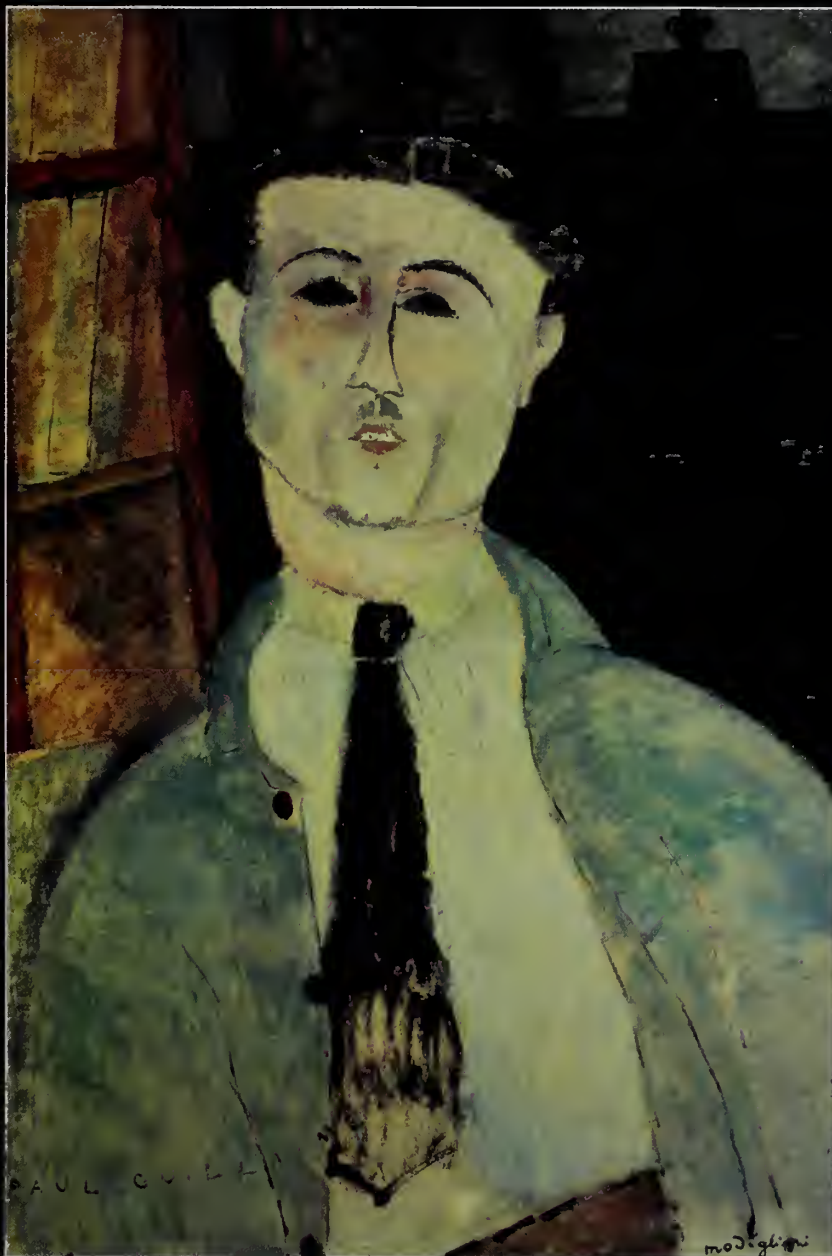
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Paul Guillaume, 1915

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Amedeo Modigliani's unique style of painting is seen in his portrait of the art dealer and author Paul Guillaume. The colors he selected were predominately earth tones. Although some have suggested that the elongated forms of Modigliani's art could have been due to an ocular defect (astigmatism), there is no data to support such a conjecture. Photo courtesy of Toledo Museum of Art. Story on 622.

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Our Good Will Toward the People of Ohio

THE OSMA'S LIVING WILL CAMPAIGN IS A GOOD EXAMPLE OF OUR SERVICE TO PATIENTS

There is a Christmas carol that reminds us that this is the time of year for "peace on earth, good will toward men."

**Joseph Sudimack,
Jr., MD**
OSMA President



As physicians, we naturally extend goodwill to our patients on a year-round basis, but it's nice to know that, as a direct result of OSMA efforts, our "goodwill to men" (and

women, of course) has just reached an even broader audience.

In October, the association launched a statewide campaign to distribute living will kits to interested Ohioans. This informative kit contains living will and durable power of attorney for health-care forms, along with directions on how to fill out these forms. Although we are charging \$2 per kit to help cover our cost of

printing and mailing, that doesn't begin to cover all of the costs associated with the campaign. However, we believe that the OSMA couldn't enter into any more worthwhile public service effort than this.

Although Ohio has had a durable power of attorney law in place for some time, the living will law is new — the result, in part, of effective and earnest lobbying by the OSMA. The living will allows Ohioans, for the first time, to make legal decisions about the type and amount of health-care they wish to receive in the event they become too sick to make their wishes known.

This type of public service campaign lets the people know that Ohio physicians are aware of their concerns about the use of death-prolonging measures, and are responsive to those concerns.

The fact that more than 18,000 orders were received within the first two weeks of the campaign not only speaks to the effectiveness of this public education effort, but also provides some insight into just how grateful Ohioans are for the initiative undertaken by our association.

The OSMA did not stop its public service, there, however. We also provided member-physicians with special physician education kits, designed to make them more familiar with the new law. Each physician education kit contains

Presidential Perspectives

copies of the living will and durable power of attorney forms, an analysis of the law and how it affects physicians, a patient education poster and a set of brochures, both of which tell your patients how they can order their own living will kits. The best part is that this kit was provided to members at no cost. (If you are a member and have not yet received your kit, contact the OSMA Department of Communications.)

In addition, the OSMA is working with the Ohio State Bar Association to form doctor/lawyer speaking teams on this issue, and we are jointly producing an educational video for use by these

teams.

So much is happening in medicine right now in the areas of access and cost, that it is easy for us, as an association, to lose sight of the need for and the importance of public service. The living will campaign is allowing us to let Ohioans know that we want to lend a helping hand with regard to a very important issue.

We, as physicians, should pat ourselves on the back for bringing public service back into the picture.

Finally, I'd like to present my own good will to all of you — my best wishes to you and your families for a happy and healthy holiday season. **OSMA**

OHIO'S LIVING WILL

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From Our Editors

New Course Set for *OHIO Medicine*

MORE PERTINENT,

TIMELY JOURNAL

DEBUTS IN JANUARY

When we were asked by then OSMA President Dr. William Marshall to chair the advisory committee of *OHIO Medicine* we anxiously anticipated the challenge of working with the editorial staff to continue the tradition of making

the journal a socio-economic resource for Ohio physicians. It was not long that we soon discovered that we may actually be at the helm of the Titanic.

In the last several years the

advertising revenue for all medical journals has been shrinking significantly without any relief in the inflationary costs of publishing and distributing. A recurrent theme in readership surveys that have been conducted by the staff at OSMA has indicated a sagging

interest in the material published by *OHIO Medicine*. The initial changes that resulted were the removal of clinical articles and an overall elimination of 40 pages from the monthly magazine. Neither of these two changes were met with significant disappointment by the readership.

In the last two years *OHIO Medicine* has developed into a trimmer news-style journal with short articles applicable to the entire medical community in Ohio. The Advisory Committee has performed a yeoman task of reviewing and revising all material to be published in *OHIO Medicine*. This has given a more pertinent and timely journal, but unfortunately, it has not been able to adequately serve the members of OSMA.

The OSMA Council directed the Department of Communications to publish multiple newsletters with timely information needed by the members of OSMA. The inherent delays in magazine publishing just do not permit timely dissemination of information that is needed in this rapidly changing medical environment.

After extensive consideration and with the "iceberg" nearing, the Advisory Committee, with the support of the OSMA Council, feels it is time to abandon the

**Richard Reiling,
MD**
Chair, OHIO
Medicine
Advisory
Committee



From Our Editors

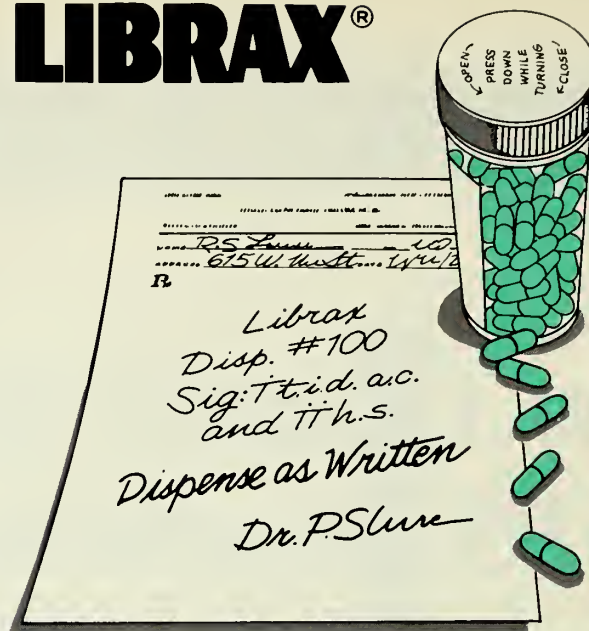
older ship for a new sleek vessel that will be timely and consolidate the multiple information papers distributed by OSMA.

The new *OHIO Medicine* will be a tabloid publication encompassing the best of the now retiring journal as well as the *OSMAgram*, the *Legislative Bulletin*, *Third-Party Update*, and the *Councilor Reports*. The Advisory Committee will continue to monitor the publication, but to expedite the dissemination of information, the editorial duties will be served by the present staff at OSMA under the Department of Communications.

So, even though we are on the bridge of the Titanic, the new course should be exciting, and helpful in keeping touch with the rapidly developing weather patterns of socioeconomic change. We know you will find the new *OHIO Medicine* useful. OSMA

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Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary.

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Revised: February 1988



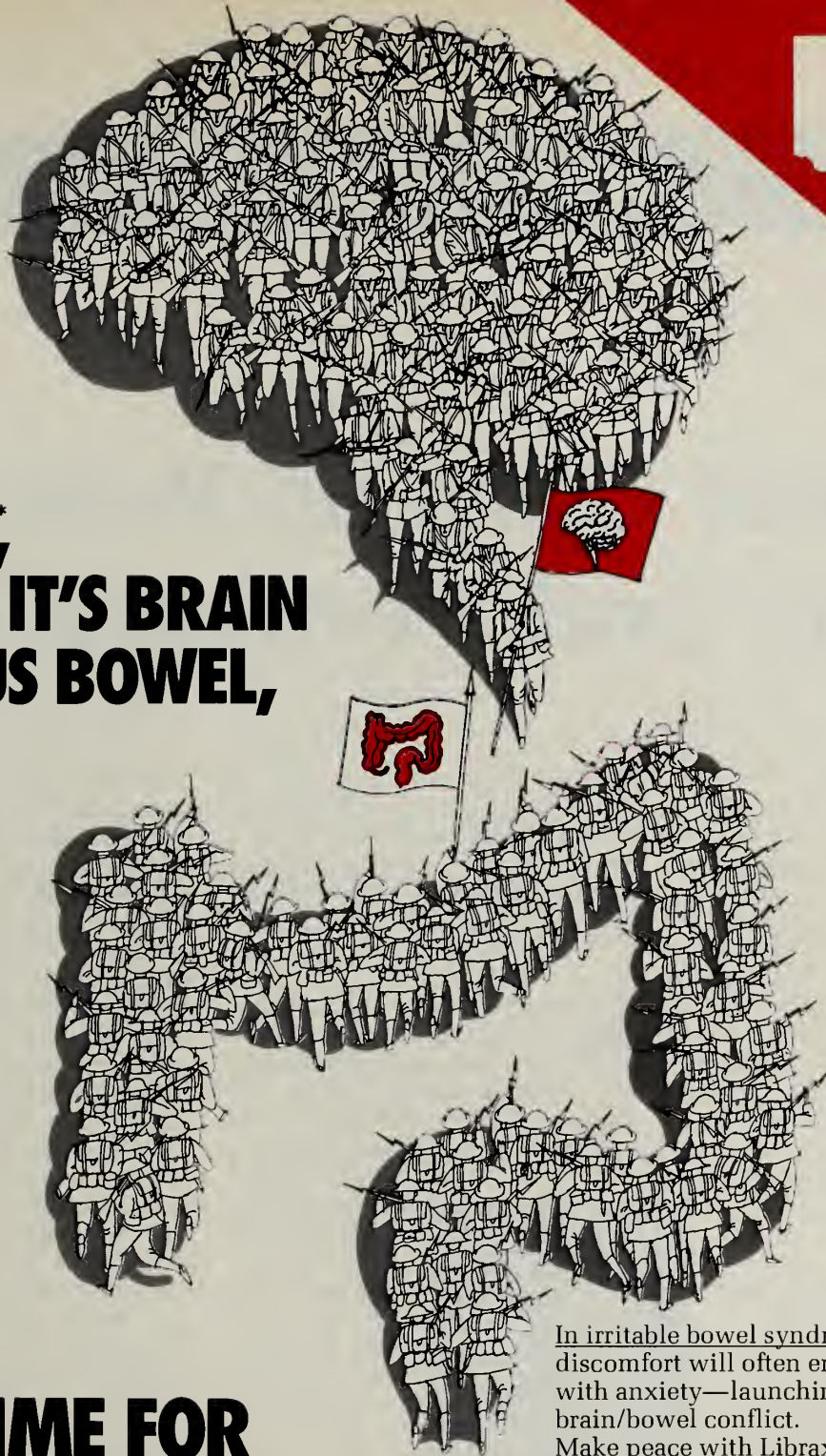
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Indirect Costs on Research Grants and Contracts

WHAT ARE INDIRECT COSTS AND WHY ARE THEY RAISING SO MUCH INTEREST?

Suddenly, there is a great deal of interest in indirect costs related to sponsored research. The public has learned about them, the media finds indirect costs to make good copy, and

some institutions (such as Stanford University) try to respond to embarrassing questions. The *Wall Street Journal* reported July 31, 1991 that "Stanford President To Resign His

Post In Wake of Scandal." Donald Kennedy, president of Stanford University, announced his retirement while investigations involving indirect costs were under way. Stanford had billed the federal government for maintenance of a yacht, flowers

and parties. A number of other research universities have offered to return some of the indirect costs to the government rather than face continuing inquiries.

Unquestionably, it is difficult to explain why taxpayers should pay for a university's art museum expenses, a trustee's retreat at Palm Springs, or executive air services (all of which were examples of alleged abuses by universities in legislative hearings).

What exactly are indirect costs and why are they raising so much interest? Simply stated, they are costs incurred in conducting research that are not attributable to a single research project or grant. For example, accounting and purchasing services, the electric bills, and expenditures for providing the laboratory or building are indirect costs. Universities allocate these costs to different pools, including administrative expenses, plant maintenance, library, student services and facility costs. They are not direct costs of the research project such as a technician's salary or the supplies used in that project. An institution allocates its expenses between its principal activities of teaching, research and services by a variety of complex accounting techniques.

A brief background of indirect costs might be in order. In the

Manuel Tzagournis, MD

Vice President for
Health Services
Dean, College of Medicine
The Ohio State University
College of Medicine



Second Opinions

1940s the government made a decision to sponsor scientific research and pay its costs, both direct and indirect. The Office of Naval Research was chosen to negotiate and oversee indirect cost agreements. In 1947 a policy was reached to apply an 8% rate for indirect costs on research grants. This amount, of course, increased with time and recently at a rapid rate. Congress approved \$8.3 billion in research funding by the National Institutes of Health (NIH) in fiscal year 1991. Naturally, NIH staff and congressmen feel that these funds could support more scientists and research projects if only indirect costs were lower. The Office of Management and Budget and staff members of federal agencies have long advocated that less money be allocated for indirect costs.

However, persuasive arguments were made to at least leave the infrastructure as solid as we found it. The educational and research institutions have prevailed in the indirect cost argument. Recently, there has been erosion of that support. Faculty members are hostile, feeling that the institution is diverting funds away from their projects. Federal agencies feel that they are being taken advantage of. But, many legislators and the public do not understand the complex system that has evolved to determine indirect costs. They wonder why there is so much variation in indirect costs among universities. For example, suppose a federal agency funded a research project last year with direct costs of \$100,000 at The Ohio State University and an identical one at Stanford University. Assume that peer review ratings were identical and the \$100,000 covered the direct costs at both institutions. The

actual award (direct and indirect costs) would be \$147,000 to Ohio State and \$170,000 to Stanford. This major difference that university and federal accountants have negotiated is quite difficult to understand.

Unlike a public high school that can allocate all of its funds on the basis of its teaching responsibilities, a university allocates its costs in some equitable way based on its teaching, service and research responsibilities. For example, some overhead costs for a library are permitted to be reimbursed from indirect costs because books and journals are used for research projects as well as teaching. Private institutions, understandably, tend to have higher costs than public universities for facilities such as laboratories. Unfortunately, a very complicated and expensive accounting system has evolved to allocate these costs.

The policy of reimbursing institutions for total costs has played an important role in the unprecedented advances in health and science knowledge in this country. Recovery of costs is essential for the foundation that will support the next generation of scientists. It is not in our best interest to dismantle the academic research enterprise that is the envy of the world. The system is in need of correction. Some suggestions to correct the situation appear quite reasonable.

Surely we can simplify the way indirect costs are determined. That will almost certainly reduce the army of fiscal personnel necessary at both the federal and institutional levels. A set of clear guidelines can be assembled to determine which costs are

acceptable for charges to indirect costs and which are not. Reimbursements should not extend beyond reasonable and real costs of research. The great variability of rates for indirect costs among institutions should be lessened. Minor adjustments over a narrow range of these costs can and should be permitted. In May 1991, the Office of Management and Budget proposed to amend circular A-21, the document that deals with indirect costs. It places a cap of 26% on the amount that institutions can claim for administrative costs. It is a reasonable change providing the cap can be adjusted with appropriate justification and it can be phased in so as not to disrupt ongoing work. The federal government should not subsidize indirect costs for research sponsored by industry and foreign governments. Finally, faculty members, elected officials and the public should be educated to understand the purpose of indirect costs and their necessity to maintain a highly desirable research enterprise in this country.

Full cost recovery should be encouraged if it is reasonable, real and verifiable. It is highly advantageous for the partnership between government and academic institutions to continue to utilize the capabilities of the nation's medical schools and hospitals for biomedical research. Let us make the necessary corrections and improvements quickly and concentrate on remaining the number one country in the world in science and health. **OSMA**

Pakistan

MEDICAL EXPERIENCES IN THE THIRD WORLD

By James Ravin, MD

Recently I had the opportunity to visit Pakistan to deliver a series of lectures on medical topics at three medical schools. I was excited about the prospect since I

had never visited that area of the world and have long been intrigued by the people, monuments, and history of the Asian subcontinent. It would be great fun to visit the area where the first of the Sherlock Holmes stories

began. As John H. Watson, MD, describes on one page of "A Study in Scarlet," he was wounded during the Second Afghan War, thrown over the back of a pack horse, and taken to safety behind

the British lines at Peshawar, the fascinating city that was to be my home for nearly a week. The British era in the Indian subcontinent was an interesting period, too. Those who have viewed "The Jewel in the Crown" on public television, or have read "The Far Pavilions" and the stories of Rudyard Kipling can understand this. It is the land of Gunga Din and includes the city of Lahore, where Kim's famous gun still stands in a traffic island facing the Lahore Museum. (Kipling's father was the first curator of the Lahore Museum). There would be a chance to travel through the Khyber Pass close to the Afghan border. I could learn about medical education in another land, make ward rounds, and see the people on their own portion of this earth. My invitation came from the Association of Pakistani Physicians of North America, the King Edward Medical College of Lahore, the Khyber Medical College of Peshawar, and the Nishtar Medical College of Multan.

A long transcontinental flight to Pakistan allowed me to become friendly with a number of other people who were part of our medical group. My sense of adventure was heightened when we lost an engine over Tehran, forcing us to make an unscheduled landing at Karachi, the former capital of Pakistan, which is located on the



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Indian Ocean. A blast of moist, hot air hit me on deplaning. The atmosphere of palm trees and tropical vegetation is like the Caribbean. During my brief stay at a Karachi hotel, I watched a cricket match between India and Pakistan on television. Although the rules of this arcane game seemed baffling, the charm and grace of the British Raj came through, temporarily transporting me back to the 19th century.

Soon we flew north to the twin cities of Rawalpindi and Islamabad. I saw little of the ancient city of Rawalpindi, which was an important military cantonment post during the British rule. A very old city, 2,000 years ago it formed part of the main road of the Silk Trade Route. Islamabad, Pakistan's capital, is unlike any other city I saw in that country, for it is a new, planned, sprawling city with few reminders of the past. It is set against the Margalla Hills, the foothills of the Himalayas in the northern Punjab. From a viewpoint up in the hills, we walked through rows of flame trees, hibiscus, and bougainvillea, and looked over the city of Islamabad as far as Rawal Lake. We visited the Shah Faisal Mosque, the world's largest, with space for 15,000 worshippers inside and another 85,000 outside in a raised courtyard. The walls are designed as an eight-sided Bedouin tent surrounded by four 300-foot-tall concrete minarets. It has walls lined with brilliant white smooth marble. The interior is decorated with mosaics and a large metal chandelier. On the grounds of the mosque is the tomb of General Zia, the recent president of Pakistan. Zia died in an airplane

crash just a few years ago.

In Islamabad our medical group attended a seminar on tertiary health-care needs at the Pakistan Institute of Medical Sciences. One of our party, Toledo surgeon Donald Martin, discussed regional trauma centers. The institute is a new facility, inaugurated in 1987, which serves as a referral center and teaching hospital for postgraduate studies. Its facilities are up-to-date, including lasers for ophthalmic care.

Some of the greatest excitement was soon to follow as we traveled from Islamabad to Peshawar. The route follows the Grand Trunk Road, an ancient highway full of historic interest. The amount of traffic is overwhelming and the road would be extremely dangerous for an uninitiated American to drive. Our driver drove skillfully and briskly with his thumb constantly on the horn. There is some semblance of order, for the sound of a horn causes slower traffic to move to the left (not the right as we expect). We flew by garishly painted trucks and buses, horse-drawn tongas and donkey-drawn carts. An occasional Mercedes would blast by us. Vendors sell fruit, meat, even sugar cane for chewing, just off the edge of the road. We saw ancient Buddhist stupas, an obelisk from the British Raj, and Moghul tombs, and only one traffic light for about 100 miles. Since most of the vehicles have no headlights or taillights, the road is extremely dangerous at night. We stopped to look at the majestic Indus River, which gave its name to India, and left the Punjab behind, entering the North West Frontier Province. We briefly deviated from the main

road to look at Attock Fort and watched a herd of goats go by. We did not have time to stop at Taxila, an important ancient site of Buddhist culture where today a large ophthalmic institution treats thousands of patients for cataracts annually. Just north of the bridge over the Indus is the confluence of the Cabul and Indus Rivers. The waters of the Cabul are muddy brown, but those of the Indus are clear blue.

In Peshawar we were guests of the mother of Toledo surgeon S. Amjad Hussain. After many warm greetings of "salaam alaykum," we enjoyed a delicious dinner. As is typical in Islamic lands, the men ate in the dining room, while the women and children retired to the kitchen area. The chicken, mutton and beef, dall (lentils) and dahi (yogurt), were scooped up with chapatis (unleavened bread). Often I did not know what I was eating, but it was extremely tasty and not overly spicy. As in most countries today, Pakistan's air suffers from a lack of emission controls on vehicles, including those powered by animals. A dark haze hovered over each major city we visited. The extensive amount of cooking and large number of factories emitting soot into the air aggravates the problem. Cities are not maintained to American standards, but there is not as much refuse as one might fear, since nearly everything is recycled in one form or another.

In Peshawar at the Lady Reading Hospital, a major postgraduate institution, I described cataract surgery as it is practiced in America today and Don Martin spoke on anatomic and physiologic concepts of enteral

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feeding.

Peshawar, the capital of the North West Frontier Province, is a frontier town where the subcontinent and Central Asia meet. Its bazaar looks like an American "Wild West" movie, but costumed as a biblical ethic. Pathan tribesmen walk down streets with their hands tucked under shawls. Afghan traders in huge turbans pass by. The bazaar is a labyrinth of twisting lanes where exotic foodstuffs, clothing and supplies are sold. I was nearly trapped between a cow's horns and a workman carrying a huge sack of grain. There are signs for doctors, lawyers and dentists. The storytellers' bazaar is overshadowed by buildings with beautifully carved balconies and window frames. Brass and copper shops line one side, pottery and blankets, shawls, paint and cloth stores on another. We climbed up to the Mahabat Kahn Mosque.

The mosque is just off the bazaar, and has a beautifully tiled minaret. Mothers today still scare children with stories of a former ruler of the city who would hang three people daily from the minaret, just to prove his power. We visited antiquarian traders, where I bought several miniature paintings very reasonably. These beautiful scenes were painted on leaves from old Arabic books. However, the paintings were "fakes" in the sense that they were recently done. Buddhist sculpture of questionable lineage was for sale. It is illegal to take out of the country anything over 100 years old. I purchased a splendid Russian officer's muskrat hat in the bazaar. These hats have come from Afghanistan, some still caked with blood (but not mine!).

Because of the Afghan hostilities, the Khyber Pass is closed to foreigners. But our group



Dr. Ravin making weapons for freedom fighters

received official permission to travel together the 35 miles through it from Peshawar to Torkham, facing the Afghan border. The terrain is rugged and barren. We could see insignia from the British era on the mountains. It is easy to understand the difficulty in defending this rough territory and, after seeing it, one might wonder why anyone would want to. We traveled past by the refugee camps that have become permanent homes for two million Afghans. Some of their high mud walls are furnished with turrets and slits for guns, and the entrances have large corrugated iron gates. At Landi Kotal we saw a smugglers' warren. Foodstuffs, electrical goods, refrigerators, cloth and drugs are sold there. A sheepskin outside a store front tells buyers that drugs are available. At Torkham military officials

described the territory for us. We were escorted through the area by tribesmen who carried automatic rifles with the safety catches off. Only the road is controlled by the Pakistani government. Inches off the road, tribal law rules.

We traveled to the gun factory town of Darra Adam Khel, south of Peshawar, another day. Special permission was also needed for this trip. In Darra the main street is lined on either side with stores, again like our old wild west. Any weapon one may desire is for sale. At any moment a customer may take an AK47 out to the middle of the street and shoot it into the air. The Darra arms industry really got started in the last century. In return for letting the Pathans develop their trade, the British were guaranteed safe passage along the main roads. Even today the Pakistani government controls only

International Health

the road. Tribal law applies on either side. Workmen labor at small forges where the guns are made by hand. With tools that seem primitive, these skilled workers create accurate reproductions of any weapon one may imagine, from pistols to anti-aircraft guns. The copies are faithful right down to the lettering of the insignia. One store owner invited us to come through to a back alley, behind the bazaar, where he demonstrated the firing of large mortar at the mountains behind us. We returned that afternoon to Peshawar, stopping in a small village for a meal. I could merely gaze in amazement at the flocks of huge crows and the patties of cow dung plastered on the sides of buildings, drying for fuel.

Next we flew to the ancient city of Lahore, where several of us spoke at the King Edward Medical College, a venerable institution with many beautiful, red brick buildings dating from the British era. I was the guest at the tallest building in Lahore, the eye hospital, and made rounds with the staff. Lahore is a fascinating city, the cultural and intellectual center of the country. Its mall and British cantonment areas are elegant. When my radiologist mentor took me to a park and departed for his afternoon prayers, I sat down to watch a group of boys play cricket. They were more interested in meeting me and touching someone with white skin. Each lined up to introduce himself and shake hands. Later we went to the Lahore Museum, a beautiful Moghul gothic structure opened in the last century. Rudyard Kipling's father was its first curator. The collections of Buddhist sculpture and Islamic manuscripts are exceptional. I was excited to see

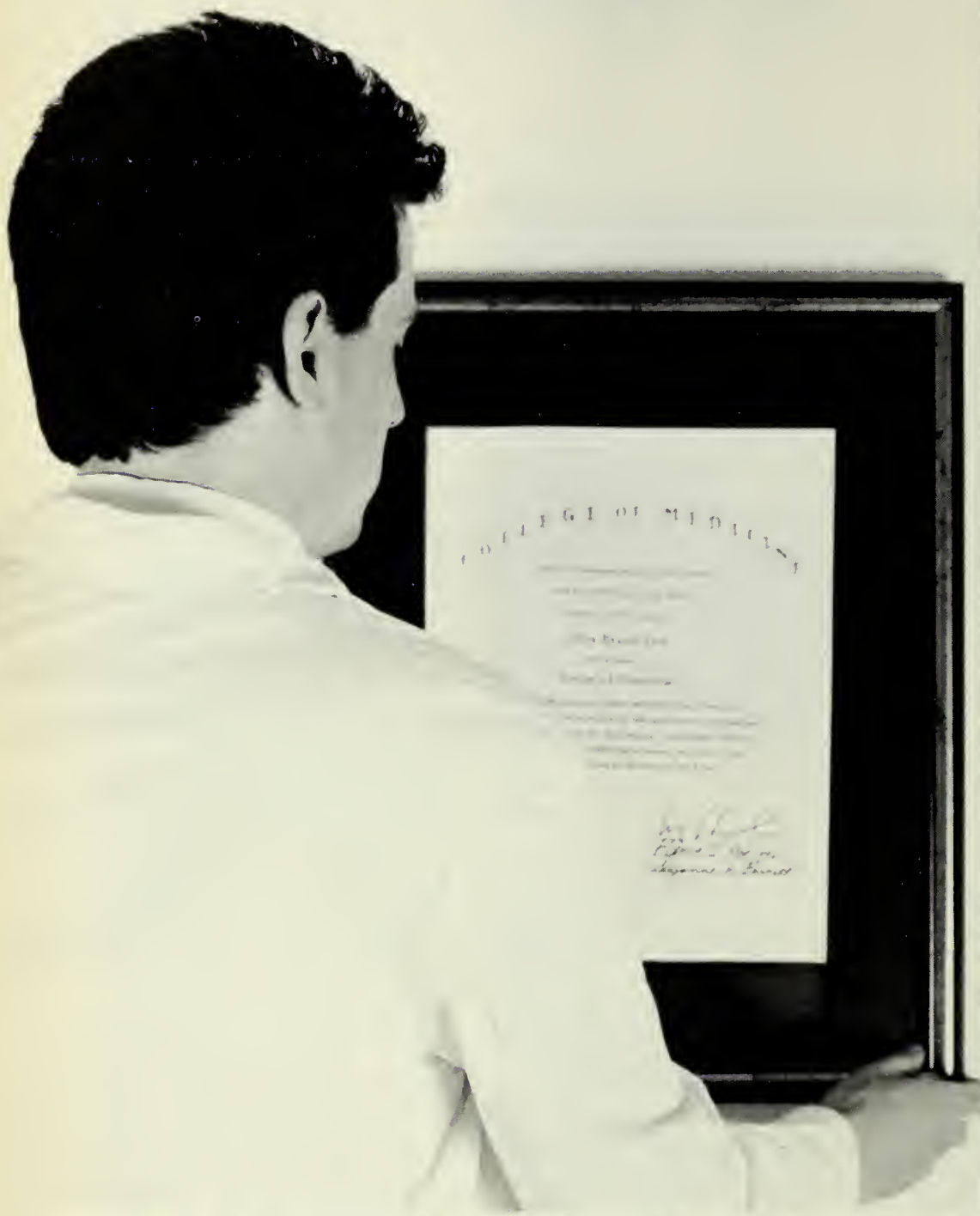
Kim's gun in front of the museum, after having read the novel years ago. The Badshahi Mosque and Lahore Fort are fascinating. Buildings within the fort were erected by several Moghul rulers, including Shah Jahan, who built similar buildings in the Red Fort at Agra, India, as well as the Taj Mahal. Also of great interest is the Manar-e-Pakistan (the tower of Pakistan), a memorial to the foundation of the Muslim League in 1940. The tomb of Ranjit Singh is another gem. It is similar to the Golden Temple at Amritsar, the holy shrine of the Sikhs. Shalimar Gardens, an impressive Moghul monument, is another beautiful site built by Shah Jahan.

Multan, a city of pirs (holy men) and shrines, was our next stop. Located in the hot southern Punjab, it is a city of dust and summer heat, but was temperate in December. The blue tiled mausoleums in the old fort are spectacular. We spoke at the Nishtar Medical College, addressing the Tenth International Scientific and Health Conference. I discussed laser therapy for glaucoma, Don Martin spoke on breast cancer, and Amjad Hussain described the life of Nishtar, for whom the medical school was named. A few of us did have time to visit the bazaar in Multan. Our driver from the medical college thought we might get lost. This proved to be impossible, for wherever we went, a curious crowd followed just to see what these foreigners were doing in their city. From Multan we went in different directions. Don Martin went to Karachi to attend a Muslim wedding. I flew to Istanbul to visit its fascinating mosques, bazaar, and Topkapi Museum. Amjad Hussain returned to Peshawar to spend more time with his family

before returning home. All of us were immensely impressed by the experience, for it offered us the chance to see a developing nation that has high-quality medical care to offer but is struggling, as we are, with the costs of delivery. In addition to the opportunity for travel, we enjoyed seeing how physicians practice medicine in a country far from the U.S.A. **OSMA**

James Ravin, MD, is chair of the Art and Culture Committee and Member of OHIO Medicine's Advisory Board.

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Why No One Can Afford to Ignore Politics

LEGISLATORS ARE DEEPLY
INVOLVED IN MEDICINE,
YET FEW MDs SHOW
POLITICAL INTEREST

By Joyce Penn



Waiting to meet with their legislators at the AMA Political Education Conference are auxiliaries: from left, Evan Valassiades, Joyce Penn, Joy Myers, Sara Rich and Dee Talmage.

critical issue in the upcoming 1992 elections. Mark Mellman, a Democratic strategist and pollster, reflected upon Americans' negative feelings (67%) when asked about the direction of our country in a

recent poll taken by the *Washington Post*. The reason for the negativism is economics: 61% feel the economy has grown worse in the last year and only 24% give it a positive rating. Health-care costs are part and parcel of the "middle class squeeze" in which Americans are caught between the costs of health care and the dollars in their wallets. Health-care costs were cited as the second greatest concern to the American public, the first were drugs and crime. When asked what changes are needed in the health-care system, 90% responded a "fundamental change or beyond."

When queried about the key criteria for health-care reform, respondents cited three issues of importance to them:

1. Lower cost;
2. Choice of doctor and hospital; and
3. Immediate access to care with the most advanced technology.

Fifty-six percent stated that they would not be willing to wait longer in a doctor's office to lower costs and 73% felt that medical costs can be reduced substantially with no diminution in quality.

Who does the public feel is responsible for the high cost of health care? The villains are listed as insurance companies (38%), doctors (27%), lawyers (16%), hospitals (12%), and all of the

Auxiliary Page

above (7%).

Throughout the conference, speakers from the American Medical Association, United States Senate, Department of Health and Human Services, House of Representatives, and Democratic and Republican national committees stressed that the cost of health care will be the dominant issue of the next decade. Robert Michel, Republican leader of the House of Representatives, compared the scope of the issue with that of civil rights in the 1960s.

Ohio physicians and auxiliaries who attended the conference are painfully aware that health care is no longer the practice of medicine, but the practice of politics. This past summer, the medical community united in a letter-writing campaign to members of Congress regarding the proposed rules for the Resource-Based Relative Value Scale (RBRVS), which were released by the Health Care Financing Administration (HCFA) in June. Over 100,000 letters from the medical community have delayed the implementation of the proposed rules, and physicians and auxiliaries attending the conference met with their congressional representatives to request support for H.R. 3070. This resolution, initiated by Rep. Pete Stark (D-Calif), opposes HCFA's proposals of a 3% or 6% behavioral offset and supports a legislative ban on the application of a behavioral offset to the conversion factor. Over 200 members of Congress have co-sponsored H.R. 3070 due, in part, to our concentrated letter-writing effort and the visits our medical community made to their congressional representatives while in Washington, D.C. for the conference.

Legislators are deeply involved in the practice of medicine, yet only two out of three physicians are involved with legislators. Our families no longer have the luxury of being uninvolved, because we will be impacted whether we like it or not. A grass-roots discussion of legislative involvement at the conference elicited the suggestion that we expand our influence to the "outer limits," that every reasonable measure be used to involve the medical family, personally and financially. Auxiliaries play a major role in medicine's image in our communities. Working together we

can reverse the decline in respect and trust that the medical profession has suffered and act as a single voice in the health legislation arena. **OSMA**

Joyce Penn is the OSMA Auxiliary President.



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Are DRGs Morally Wrong?

Physicians who have spent the last 10 years working their Medicare patients through the prospective payment maze that's based on diagnostic-related groups (DRGs) may derive some comfort from Carl Cohen, a philosophy professor from the University of Michigan who served as this year's Fulton Memorial speaker, an annual lecture series that commemorates Columbus physician and former OSMA President Richard L. Fulton, MD.

As far as Cohen is concerned, there is nothing moral about DRGs. In fact, he says, DRGs create a health-care environment that is far from wholesome — for either the physician or the patient.

"There are reasons for my hostilities, though," he says.

Cohen enumerated both short-run and long-run evils that are inherent in a prospective payment system — a system that he says is not designed to provide care, but to protect the third-party payors.

Short-term problems include:

- **Forced tensions between hospital administrators and physicians**

"When a hospital is not operating in the black, and most of its payments are from DRGs,

the hospital can't shift costs," Cohen says.

Instead, the hospital closes, or it pressures physicians to remove their more "costly" patients from the hospital setting.

"Does this mean, sometimes, patients are sent out too soon?" asks Cohen. "Yes. Are physicians doing less for patients?" he asks again. "In some cases, yes."

Cohen is quick to point out, though, that there are "no villains in this piece. It's the *system* that creates the conflicts.

"The problem with DRGs is that they have created all these invisible conflicts," Cohen continues. He points out that invisible conflicts exist between physicians and patients, hospitals and patients, physicians and hospitals and physicians and themselves.

"When a doctor sends a patient to a lab in which he has financial interest, he gets money, maybe the hospital gets some money, but the patient doesn't know this is going on. It's this hidden factor that's bad," says Cohen. "And it's the hidden factor, the decisions that are made behind the scenes that makes DRGs so bad."

- **Physicians as gatekeepers**

DRGs are forcing physicians to decide *who* gets treatment and what *kind* of treatment these patients should receive — another short-term failing of the prospective payment system, says Cohen.

"It's not fair for physicians to have this 'gatekeeper' duty," he says, pointing out that physicians are not well-trained to make these decisions. "If these kinds of decisions need to be made, then society, as a whole, needs to make them. It should not leave that responsibility to physicians alone."

Other, long-term evils exist within a prospective payment system, says Cohen. These include:

- **Aggravating conditions of poverty**

As far as diagnostic related groups are concerned, poor, sick patients are unprofitable.

"Does that mean hospitals turn these patients away?" he asked. "Yes, some do," he replied. That, in turn, aggravates and perpetuates the poverty cycle.

- **Stratifying hospital patient mix**

These days, hospital trade publications are full of articles on "how to avoid hospital out-layers." "In other words," Cohen

Reimbursement

paraphrases, "How to avoid sick people."

DRGs are causing hospitals to adopt policies that attract wealthy, paying patients and avoid those who are very poor or very sick, an attitude that is extending into hospital services, as well.

"Some hospital procedures are profitable, some aren't," notes Cohen. As a result, some hospitals are pressuring physicians to make treatment decisions on who's receiving the treatment and how it will be paid for. As an example, Cohen points to those hospitals that urge amputation over costly, orthopedic surgery for seniors who are, traditionally, low-paying patients.

Even helicopter services are voluntarily curtailed by hospitals, "because they bring in the kind of patients hospitals don't want," says Cohen. "These are expensive patients, by the nature of their injuries, and because they are usually life-flighted from rural areas, they're not always well-paying patients." The hospital helicopter service is good public relations, says Cohen, but if it comes to a matter of cutting services, this is generally the first one cut.

• Discouraging advancements

"Hospitals need to invest in technology, but often they don't have the means," says Cohen.

Unfortunately, the monies needed cannot be generated by DRGs, which already barely cover costs.

Medical education, too, is stymied by a system that doesn't pay teaching hospitals enough incentive to cover the costs of training.

"The long-term vision isn't a happy one," says Cohen. "DRGs are, fundamentally, the wrong spirit. We shouldn't be treating patients as though they are only

members of a diagnostic-related group — the gall bladder in Room 312. The enthusiasm for DRGs expressed by the government and third parties is not in the profession's best interest. If health care is to be rationed, then a more rational approach needs to be taken."

Cohen doubts, however, that just because the system is morally and ethically wrong, it can or will be stopped.

"I'm a jackal," he comments, "and the caravan keeps marching. It's not going to stop just because I'm barking." OSMA

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Proposed Revision of OSMA Constitution and Bylaws

In June, 1990 the Council of the Ohio State Medical Association decided to review the OSMA Constitution and Bylaws for the first time in twenty years. Council referred the initial review to the Committee on Judicial and Professional Relations. The Judicial and Professional Relations Committee and the Council considered a multitude of policy issues and debated several of them extensively. The resulting amendments were proposed to the 1991 House by the Council as Resolution 71-91. The proposed changes did not significantly alter the OSMA's structure or policy making process. Rather, the Council believed the amendments would give the OSMA the flexibility to meet the challenges facing the OSMA membership and their patients in the next decade.

At the 1991 House of Delegates, Resolution Committee #4 held a hearing on the resolution and submitted its report to the final session of the House. At that time, the House voted to defer consideration of the committee's report, and in effect, postponed consideration of the report and Resolution 71-91 until the 1992 House of Delegates.

After the Annual Meeting, the OSMA Council directed staff to redistribute Resolution 71-91 and the committee's report to the

House of Delegates for comments. The Resolution Committee was charged with reviewing the comments submitted by members of the House of Delegates. The Resolutions Committee reviewed comments at its meeting on November 6 and submitted additional changes to the OSMA Council. The 1991 work product of the Resolutions Committee was approved by Council at its November 15, 1991 meeting. The resulting document is printed here, and will be submitted to the 1992 House of Delegates. Any member may submit a resolution regarding the Constitution and Bylaws by sending it to OSMA by March 2, 1992.

Summary of Major Issues Presented

I. The Council considered the disciplinary process of the OSMA in light of the enactment of the Health Care Quality Improvement Act of 1986. OSMA Counsel Bill Todd, J.D. and Terri Lynn Smiles, J.D., (outside Counsel to OSMA) reviewed the relevant sections of the Constitution and Bylaws. At their recommendation the Council proposed these modifications so that our Bylaws will comply with the mandates of the Federal statute. Compliance with the statute will give the OSMA increased protection from antitrust litigation. The new language also

recognizes the necessity of reporting final OSMA disciplinary actions to the National Practitioner Data Bank. The protection of OSMA officers and employees from liability for actions performed in the course of their duties has also been expanded. These modifications reflect recent statutory changes in Chapter 1702 of the Ohio Revised Code that permit indemnification and protection of officers, employees, and members of committees or commissions of the Association. (See Chapters 1, Section 6 and 7; Chapter 11, Section 6; Chapter 15)

II. The Council recommended changes in the current membership classifications to separate and identify "Retired Members" and to establish a prerequisite for becoming a "Retired Member." This qualification requires prior active OSMA membership of at least (10) years. Also, it is necessary that the individual not receive regular and significant income for any professional activity related to the practice of medicine. The Council restates the Council's existing right to set dues for all membership classes, now including retired and corporate, except Active Members. The Council proposes the elimination of the Life Active Members classification. Those who have already purchased Life Active Memberships will continue as

OSMA Constitution and Bylaws

Active Members. (See Article III and Chapter 1, Section 2)

III. The Council recommended that past presidents of the OSMA be considered delegates to the OSMA House with the right to vote. They presently have the privileges of the floor without the right to vote. The Resolutions Committee disagreed for the reasons included in the comments section. The proposal now does not give Past Presidents a vote in the OSMA House unless they are elected by their delegation. (See Article IV)

IV. The Council recommended that all members of Council have a vote. Currently the representatives from the OSMA-HMSS Section, the Residents Section and Student Member Section are elected to non-voting seats on Council. The Council believes that every member of the Council should have the right to not only participate in the Council's deliberations, but also to vote on the issues discussed. (See Constitution — Article VII)

V. (a) The Council recommended changes in the Annual Meeting structure which give the Delegates the flexibility to design the Annual Meeting to better meet their needs. The revision also eliminates the scientific program and the scientific sections which have not been part of the Annual Meeting for several years. (Chapter 3, Section 3-9)

(b) The Council endorsed the elimination of references in the OSMA Constitution and Bylaws to a scientific meeting and a scientific journal. The Council concluded from membership studies and its perceptions of members' needs, that the OSMA no longer has a primary role in scientific education or producing scientific publications. The Council modified the purposes section of

the Constitution to better reflect the priority activities of the OSMA. (Article I, Section 2 (4) & (5))

(c) While the Council recommended establishing a required percentage of sixty (60%) percent of OSMA members in a specialty society that wishes to have a Delegate in the OSMA House of Delegates, the Resolutions Committee disagreed and recommended no minimum percentage. The Council deliberated this issue and failed to reach a consensus on this proposed revision. The proposal now contains no minimum percentage (See Chapter 3 and Chapter 4, Section 3)

(d) The Council removed the specific Order of Business currently in the Constitution and replaced it with the Sturgis General Order of Business. The Order of Business can be modified before any session by the presiding officer with the consent of the House of Delegates. (See Chapter 3)

VI. The Council reviewed the duties and responsibilities of the Officers, Executive Director and Council and redrafted parts of those sections to better represent the current administrative responsibilities and organizational activities of those individuals. (See Chapters 7, 8 and 9)

VII. Council recommended giving the President the authority to create Committees and Task Forces annually. The only mandated Committees continued will be Judicial and Professional Relations, Auditing and Appropriations, Resolutions, Tellers and Judges and Nominations. Other current Committees may continue depending on the needs of the OSMA membership as ascertained annually.

VIII. The Council revised the

component societies section to permit individuals to be Active Members in multiple county societies. However, the revision does not permit these physicians to be counted in more than one (1) component society as an Active Member for OSMA House of Delegates representation. (See Chapter 11, Section 1)

IX. The proposed changes to Chapter 11, Section 6 grant OSMA Council greater latitude in handling appeals from decisions of a component society. Council would have the discretion to decline to hear the appeal. It should be noted that under the draft Model County Bylaws that were circulated in 1990 there is an internal appeal process at the component society level. Accordingly, an appeal to OSMA Council actually would be a second level appeal, and, therefore, could be made discretionary.

In addition, the proposed changes include the ability of Council, after hearing the appeal to remand the matter to the component society for further consideration. This option can be used if the component society made technical errors in its process or did not consider some relevant evidence. These changes also clarify that except in extraordinary circumstances, peer review is the responsibility of the component society.

X. The Constitution and Bylaws have been rewritten in a gender neutral format pursuant to House of Delegates mandate.

CONSTITUTION AND BYLAWS OF THE OHIO STATE MEDICAL ASSOCIATION

CONSTITUTION

ARTICLE I NAME AND PURPOSES

Section 1. Name. The name and title of this corporation shall be OHIO STATE MEDICAL ASSOCIATION.

Section 2. Purposes. The purposes of this Association shall be:

(1) To bring into one organization the physicians of the State of Ohio and through this, and similar societies of other states, to maintain and support the American Medical Association.

(2) To formulate and maintain educational programs designed to provide better service to the public in matters of personal and public health.

(3) To encourage among members of the medical profession the interchange of views on all phases of medical science, to the end that each member of the profession may be better equipped to serve society and promote the health of the public.

~~(4) To maintain programs of scientific education keyed to the constant advancement of the science of medicine and to foster, encourage, and coordinate post-graduate educational facilities for the medical profession as a whole.~~

~~(5) To disseminate, among members of the profession, by means of scientific publications and otherwise, information reflecting advances in medical research.~~

(64) To maintain and advance the standards of medical practice in this state by requiring ~~strict~~ adherence by the members of the profession to the ~~highest~~ concepts of professional ethics.

(75) To study, ~~and~~ formulate methods of AND PROVIDE INFORMATION ON health care delivery with particular emphasis on efficiency and availability SYSTEMS.

(6) TO REPRESENT THE OPINIONS AND POLICY POSITIONS OF THE MEMBERS, AS APPROVED BY THE HOUSE OF DELEGATES OR THE COUNCIL, BEFORE GOVERNMENTAL BODIES AND AGENCIES.

(87) To carry on such functions and activities as are deemed necessary or desirable to effectuate the above purposes.

The following proposed revisions of the OSMA Constitution and Bylaws include the revisions proposed by the Judicial and Professional Relations Committee and Resolutions Committee #4 at the 1991 House of Delegates and approved by the Council at its November 1991 meeting. Recommended changes are identified as follows:

Existing language to be deleted is written in regular type with hyphens through the type. Proposed new language is CAPITALIZED (Example: ~~one~~ TWO).

ARTICLE I, SECTION 2 - Item 4 - Deletion. Surveys of OSMA members have shown that they no longer look to the OSMA to develop and maintain programs of scientific education nor do they expect the OSMA to coordinate postgraduate education. These activities are being fulfilled by other organizations far more efficiently and successfully than the OSMA.

SECTION 2 - ITEM 5 - A comprehensive survey of the members was conducted in 1990 and readership surveys over the last several years have drawn us to the conclusion that the members do not look to the OSMA to disseminate scientific information or information regarding medical research. This information is provided by others.

REVISION OF ITEM #7 (now #5) - Members expect us to provide information on healthcare delivery systems.

NEW #6 - The Association's members have directed that the primary responsibility of the organization is to represent the opinions of the majority of our members to the governmental bodies and agencies.

ARTICLE II COMPONENT SOCIETIES

Section 1. Definition. Component societies shall consist of those county medical societies which now hold, or may hereafter receive, charters from this Association.

Section 2. Geographical Scope. Not more than one component society shall be chartered in any one county; provided, however, that a charter may be granted to a society comprising two or more counties, or parts thereof, when, in the judgment of the House of Delegates, the chartering of a multi-county society is in the best interests of this Association; and provided further, that whenever two or more component societies holding charters from this Association shall request in writing that they be organized into a single multi-county society, the House of Delegates may grant a charter to such ~~multi-county society; such multi-county society to be officially designated by hyphenating the names of the counties comprising such multi-county organization.~~

Section 3. Membership in Adjoining Society. If there ~~should be~~ IS an insufficient number of physicians in any county to form ~~themselves into~~ a component county society, such physicians may become members of the component society of an adjoining county, if they are otherwise eligible under the Constitution and Bylaws of such adjoining component society.

ARTICLE III COMPOSITION OF THE ASSOCIATION

Section 1. Classes of Members. The Association shall consist of the following classes of members:

1. Active Members (~~including retired active members~~)
2. ~~Associate Members~~ RETIRED MEMBERS
3. Members in Training
4. Non-resident Members
5. Honorary Members
6. Military Members
7. Affiliate Members
8. Student Members.
9. Corporate Members

Section 2. Voting Members. The voting members of this Association shall consist of ~~each of~~ those physician members of the component societies who ~~has~~ HAVE complied with the eligibility requirements of Chapter 1 of the Bylaws of this Association, ~~and who has~~ HAVE been certified by the appropriate officer of his/HER component society as being an Active Member, RETIRED MEMBER or a Member in Training in good standing of such society, and whose dues and assessments in this Association for the current year have been received at the headquarters of this Association; ~~provided, however, that~~ The foregoing provision regarding receipt of dues and assessments shall not apply to members exempted from the payment of dues and assessments under the provisions of Chapter 2 of the Bylaws of this Association, or to members whose dues and assessments have been waived.

ARTICLE IV HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of this Association and shall consist of: (1) delegates elected by the component societies; (2) officers of the Association enumerated in Article VI; (3) DELEGATES AND ALTERNATE DEL-

ARTICLE III - Deletes Associate Members (no longer utilized at the OSMA). This deletion does not however, restrict the county medical societies from having a category of Associate Members, if they choose to do so.

ARTICLE IV - Section 3 simply includes moving former number (5) within this section. In earlier drafts, the Council had recom-

EGATES TO THE AMERICAN MEDICAL ASSOCIATION FROM OHIO, PAST PRESIDENTS AND PAST COUNCILORS OF THIS ASSOCIATION EACH OF WHOM SHALL BE AN EX-OFFICIO MEMBER WITHOUT RIGHT TO VOTE UNLESS SUCH DELEGATE, ALTERNATE DELEGATE OR PAST PRESIDENT BE A DULY ELECTED DELEGATE FROM A COMPONENT SOCIETY OR A DULY ELECTED OFFICER OF THIS ASSOCIATION; and (34) such representatives of other medical groups as may be determined by the House of Delegates; INCLUDING THE FOLLOWING:

The Medical Student Section shall have ~~six~~ SEVEN (7) representatives to the House of Delegates ~~commencing with the Annual Meeting in 1982~~, said delegates to be selected in accordance with the Bylaws of the Medical Student Section; PROVIDED THAT THE BYLAWS OF THE MEDICAL STUDENT SECTION HAVE BEEN ~~to be~~ approved by Council. For purposes of representation in the House of Delegates, Student Members shall not be counted at the individual district level, but shall constitute a separate section which shall be treated and seated as if it were an additional district in which the Student Members of each OHIO medical AND OSTEOPATHIC MEDICAL school elect their own delegate;

~~t~~The Hospital Medical Staff Section shall have one representative to the House of Delegates ~~commencing with the Annual Meeting in 1985~~, said delegate to be selected in accordance with Bylaws of the Medical Staff Section; PROVIDED THAT THE BYLAWS OF THE HOSPITAL MEDICAL STAFF SECTION HAVE BEEN ~~to be~~ approved by Council.

~~(4)t~~The Resident Physician's Section shall have one representative TO THE HOUSE OF DELEGATES who must be a Member in Training of the OSMA, said representative to be SELECTED IN ACCORDANCE WITH THE RESIDENT SECTION BYLAWS; PROVIDED THAT THE BYLAWS OF THE RESIDENT PHYSICIAN'S SECTION HAVE BEEN approved by Council. ~~selected in accordance with the Resident Section bylaws to be approved by Council; and (5) delegates and alternate delegates to the American Medical Association from Ohio, Past Presidents and Past Councilors of this Association each of whom shall be an ex-officio member without right to vote unless such delegate, alternate delegate or past president be a duly elected delegate from a component society or a duly elected officer of this Association.~~

THE PRIMARY MEDICAL SPECIALTIES LISTED BY THE AMERICAN BOARD OF MEDICAL SPECIALTIES ARE ELIGIBLE TO HAVE A DELEGATE AND ALTERNATE DELEGATE TO BE SELECTED IN ACCORDANCE WITH CHAPTER 4, SECTION 3 OF THE BYLAWS OF THIS ASSOCIATION.

mended that the Past Presidents of the Association who have registered be voting delegates at the House of Delegates. The Reference Committee, after hearing testimony, concluded that this recommendation would not be part of their report. The Resolutions Committee has recommended that Past Presidents NOT be voting members of the House of Delegates unless they are elected by their delegation. After consideration of the issue the Committee rejected the proposal for the following reasons:

1. Past Presidents have no specific constituency to represent;
2. A district with several Past Presidents would have voting strength disproportionate to its actual number of physicians;
3. The AMA only grants Past Presidents the right to serve as ex-officio members without the right to vote;
4. A Past President of the OSMA is eligible to serve as a voting delegate of any delegation, if elected by a component society of section.

At the November 1991 meeting, Council concurred with the Committee's recommendations.

ARTICLE IV - clarifies membership eligibility for students at Ohio University school of Osteopathic Medicine. Current OSMA Bylaws permit holders of D.O. degrees to join OSMA. This addition states the fact that osteopathic medical students can join the OSMA as student members. Current OSMA and Medical Student Bylaws permit them to be members.

Other changes to this Article are editorial.

ARTICLE V MEETINGS

Section 1. Annual Meeting. This Association shall hold an Annual Meeting, ~~during which there shall be sessions of the House of Delegates, general sessions, meetings of specialty sections and meetings of specialty societies, all of which shall be open to all registered members and registered guests:~~

Section 2. Time and Place of Annual Meeting. The time and place for holding each Annual Meeting shall be fixed by the Council of this Association.

Section 3. Special Meetings. Special meetings of the House of Delegates shall be called by the President or other officer upon a two-thirds vote of the Council or upon the filing, with the Executive Director of this Association, of a petition duly authorized and signed by the presidents of at least twenty-three (23) component societies. Within ten days after such action of the Council, or the filing of such petition, the Executive Director shall give written notice to the members of the House of Delegates; setting forth the purpose or purposes of such ~~called~~ meeting and specifying the time and place thereof; ~~which time of~~ IN NO EVENT SHALL THE meeting ~~shall in no event~~ be less than twenty (20) days nor more than sixty (60) days after the mailing of such written notice.

ARTICLE VI OFFICERS

Section 1. General. The officers of this Association shall be a President, a President-Elect, the Immediate Past President, a Secretary-Treasurer, and Councilors.

Section 2. Election and Eligibility. The officers of this Association shall be elected by the House of Delegates. ~~during the Annual Meeting.~~ No person shall be eligible for an elective office who has not been an Active VOTING Member or ~~Member in Training~~ of this Association during the entire preceding two years. The terms of the officers of this Association shall be ~~such as are~~ prescribed by Chapter 6 of the Bylaws of this Association.

ARTICLE VII THE COUNCIL

~~The Council~~ THE BOARD OF TRUSTEES (REFERRED TO HEREIN AS "THE COUNCIL") shall consist of one Councilor from each Councilor district, one ~~non-voting~~ member from the Hospital Medical Staff Section, one ~~non-voting Councilor~~ MEMBER from the Resident Physician's Section, one ~~non-voting~~ Student Member from the Medical Student Section and the other elected officers of this Association. The Council shall be the executive body of this Association and it shall have the complete custody and control of all funds and property of this Association and shall have and exercise full power and authority of the House of Delegates between meetings of the House of Delegates.

ARTICLE VIII FISCAL YEAR

The fiscal year of this Association shall begin on January 1 and end on December 31.

ARTICLE IX SEAL

This Association shall have an official seal bearing the legend "Ohio State Medical Association - 1846." The power to change or renew the seal shall rest with the House of Delegates in conformity with the laws of the State of Ohio.

ARTICLE V - Proposed change deletes the requirement that there are meetings of Specialty Sections and Specialty Societies at the Annual Meeting. These meetings have not been part of the Annual Meeting since 1987.

The proposed revisions give the delegates the opportunity to experiment with alternative Annual Meeting programs. The Annual Meeting no longer contains scientific sessions. (See other amendments.) This proposal does not eliminate the Annual Meeting, but gives the House the ability to restructure the Annual Meeting in order to accomplish the goals the House defines for it.

ARTICLE VII - Council recommends permitting the Councilors from the Hospital Medical Staff Section, the Resident Physician Section, and the Student Section, to be voting members of Council.

ARTICLE X REFERENDUM

By a two-thirds vote of the delegates present at a meeting of the House of Delegates, a general referendum shall be held upon any question then pending before it;

~~and~~ Upon a petition duly authorized and signed by the governing bodies of at least one-half of the component societies and filed with the Executive Director on or before the thirtieth (30th) day following the adjournment of a meeting of the House of Delegates, a general referendum shall be held upon any action taken at such meeting.

The procedure to be followed in connection with the submission to a referendum of any referred question or action shall be ~~that~~ AS set forth in Chapter 14 of the Bylaws of this Association; ~~provided, however, that if~~ IF the referred question ~~be IS with~~ IN respect to a proposed amendment to this Constitution, an affirmative vote of two-thirds (2/3) of those voting in such referendum shall be required to determine the referred question; ~~and provided, further, that~~ FURTHERMORE, if the referred action of the House of Delegates ~~be with~~ IS IN respect to the adoption by the House of Delegates of an amendment to this Constitution, a vote of two-thirds (2/3) of those voting in such referendum shall be required to reject and nullify the action of the House of Delegates in adopting such amendment.

ARTICLE XI

Section 1. Method of Amending. The House of Delegates may amend any article of this Constitution by a two-thirds (2/3) vote of the delegates and officers registered at the Annual Meeting or at any special meeting called for that purpose provided, however, that such proposed amendment shall have been published ~~in BY The Journal of~~ this Association, or sent ~~by first-class mail~~ to all VOTING Members of the Association, at least ~~sixty (60)~~ THIRTY (30) days before such meeting and that a true and correct copy thereof shall have been sent ~~by first-class mail~~ to the secretary of each component society at least thirty (30) days before ~~each~~ SUCH meeting.

This change permits the House of Delegates to amend the Constitution after thirty (30) days notice to all Voting Members of the Association. Currently the notice must be given sixty (60) days in advance by first class mail.

Section 2. Conformity by Component Societies. When an amendment to this Constitution has been duly adopted, the secretary of each component society shall be notified in writing by the Executive Director within sixty (60) days after such amendment has become effective. It shall become incumbent upon each component society to make such change in its constitution and bylaws; or, ~~if the society be a corporation, in~~ its articles of incorporation and code of regulations or other fundamental body of rules for the government of the corporation, as will bring about conformity to the change in the Constitution of this Association. The secretary of such component society shall file with this Association a copy of such changes in the component society's constitution and bylaws together with written notice of compliance with the provisions of this section within one hundred and eighty (180) days after IT RECEIVES NOTICE. ~~notice shall have been given by the Executive Director to such component society.~~

ARTICLE XII

Upon the adoption of this Constitution by a two-thirds (2/3) vote of the delegates and officers present and voting, this Constitution will become effective and thereupon all previous Constitutions shall be rendered null and void ~~of no effect~~.

BYLAWS

CHAPTER 1 MEMBERSHIP

Section 1. Rights of Members. All members in good standing of this Association shall have the right to attend all meetings of the Association. ~~and to take part in all the scientific proceedings of the Annual Meeting.~~

Section 2. Classification of Membership.

(a) Active Members. Active Members of this Association shall comprise all the active members in good standing of the several component societies. Active Members in good standing ~~of this Association~~ shall have the right to vote and hold office.

~~(b) Associate Members. Associate Members of this Association shall comprise all those members in good standing of the several component societies who hold an associate membership, or other probationary or provisional type of membership of limited duration, in a component society.~~

RETIRED MEMBERS. RETIRED MEMBERS OF THIS ASSOCIATION SHALL BE THOSE MEMBERS OF THIS ASSOCIATION WHO HAVE RETIRED FROM THE ACTIVE PRACTICE OF MEDICINE AND WHO DO NOT RECEIVE REGULAR AND SIGNIFICANT INCOME FOR THEIR PARTICIPATION IN ANY PROFESSIONAL ACTIVITY RELATED TO THE PRACTICE OF MEDICINE. THEY MUST BE RETIRED MEMBERS OF THEIR COMPONENT SOCIETY AND MUST HAVE BEEN ACTIVE MEMBERS OF THIS ASSOCIATION AND IN GOOD STANDING FOR TEN (10) YEARS PRIOR TO RETIREMENT. RETIRED MEMBERS SHALL HAVE THE RIGHT TO VOTE AND HOLD OFFICE.

(c) Members in Training. Members in Training shall comprise all those members in good standing of the several component societies who are pursuing studies and training in a program accredited by the American Medical Association OR THE AMERICAN OSTEOPATHIC ASSOCIATION and ~~its~~ THEIR associated groups. Members in training in good standing of this Association shall have the right to vote and hold office.

(d) Nonresident Members. Nonresident Members shall ~~also~~ include those physicians who reside and practice outside Ohio but who hold Ohio licenses to practice medicine and surgery and who are not eligible for ACTIVE membership in a component society of this Association and who are approved for Nonresident Membership by the Council.

(e) Honorary Members. The House of Delegates may elect as an Honorary Member any person distinguished for his services or attainments in medicine or the allied sciences or who has rendered other services of unusual value to medicine. An Honorary Member shall pay no dues or assessments.

(f) Military Members. Military Members comprise all those Active Members of this Association in good standing who are serving a limited tour of active duty with the Armed Services of the United States.

~~(g) Life Active Members. Any Active Member of this Association who shall make a single payment of \$3,000.00 for lifetime membership dues, shall become a Life Active~~

Section 1. This change deletes reference to scientific proceedings at the Annual Meeting. The OSMA Annual Meeting no longer contains scientific proceedings.

Section 2 (B). This deletion eliminates the classification of "associate members" at the OSMA. Associate membership is no longer used at the OSMA. This change does not prohibit the utilization of associate members at the county level. Associate members at the county level will be carried as active members at the OSMA.

The capitalized language redefines the classification of retired members. The restriction on retired membership requires the individual not to receive regular and significant income for any professional activity related to the practice of medicine. They also must have been members of the component society and the OSMA for at least ten (10) years prior to retirement. Retired members retain the right to vote and hold office.

Section 2 (C). Adds the American Osteopathic Association to the members in training classification, thereby permitting individuals in residency programs approved by the American Osteopathic Association to be members of the OSMA. Current OSMA Bylaws permit holders of M.D. and D.O. degrees to be members of the association.

Section 2 (D). Inclusion of "ACTIVE" prior to membership clarifies a classification and permits this classification and permits individuals to be eligible for membership in the component societies of this association if they are approved by Council and practice outside of Ohio.

Section 2 (G). This change deletes the life active membership classification, a classifi-

~~Member of this Association and shall not be assessed additional membership dues during his lifetime. This membership shall be limited to the first 500 Active Members who make a single lifetime membership dues payment.~~

(hG) Affiliate Members. Executives of the Ohio State Medical Association, county medical societies, and other medical organizations and specialty societies in Ohio with three years or more experience in the sponsoring organization OR INDIVIDUALS RECOMMENDED BY A COMPONENT SOCIETY are eligible for Affiliate Membership in the Ohio State Medical Association. Such Affiliate Membership shall be at the pleasure DISCRETION of the Council. ~~An Affiliate Member shall pay no dues or assessments.~~

(iH) Student Members. Student Members of this Association shall comprise those students in good standing who are pursuing the diploma of Doctor of Medicine or Doctor of Osteopathy in an approved medical or osteopathic college or institution in the State of Ohio and are approved for Student Membership by the Council. Student Members shall comprise the medical group known as the Medical Student Section. Said section shall be governed by and operate under separate Bylaws approved by the Council. Except as otherwise provided in Article VII of the Constitution, Student Members in good standing of this Association shall have the right to vote and hold office in this Association.

(jI) Corporate Members. Medical partnerships and corporations, one or more of whose members or employees is an Active Member of this Association, are eligible for Corporate Membership in Ohio State Medical Association. Such Corporate Membership shall be at the pleasure DISCRETION of the Council. ~~A Corporate Member shall pay no dues or assessments and the privileges of a Corporate Member shall be determined by the Council.~~

Section 3. Eligibility. (a) To be eligible for any class of membership other than honorary, affiliate, RETIRED, or student, OR CORPORATE in this Association, a person shall possess all of the following qualifications ~~to wit: He~~ A PERSON must hold a limited, temporary, or unlimited certificate to practice medicine and surgery, or osteopathic medicine and surgery, issued by the licensing authority of the State of Ohio, which license must be in full force and effect at the time of ~~his~~ THE PERSON'S application for membership in this Association.

(b) TO BE ELIGIBLE FOR ANY CLASS OF MEMBERSHIP OTHER THAN HONORARY, AFFILIATE OR STUDENT IN THIS ASSOCIATION ~~He~~ A PERSON must be a member in good standing of a component society.

Section 4. Disqualification. No person who is under sentence of suspension or expulsion from any component society of this Association, or whose name has been dropped from such society's roll of members, shall be entitled to any of the rights or benefits of this Association.

Section 5. Effect of Expiration, Revocation, or Termination of Certificate. Membership in this Association of a member in active practice whose certificate to practice medicine and surgery has expired, has been revoked, or has been otherwise terminated, shall be cancelled automatically as of the effective date of such expiration, revocation or termination. The provisions of this Section 5 shall not apply to members who have retired from active practice or to members whose certificate has been voluntarily surrendered due to illness, or to members whose license has automatically expired because of problems of communication.

Section 6. Disciplinary Procedure. Disciplinary action may be taken by this Association against a member of this Association only upon written charges signed by three or more members of this Association and filed with the Executive Director. STANDARD PROCEDURE FOR DISCIPLINARY ACTIONS REQUIRES THAT A COMPLAINT BE INITIALLY FILED WITH AND WHENEVER POSSIBLE ADJUDICATED BY THE COMPONENT SOCIETY OF WHICH THE PHYSICIAN IS A MEMBER. As soon as possible, and in any event not later than ten (10) days after such filing, the Executive Director shall serve upon the accused member a true copy of such

cation that has not been utilized in the association since 1978. Individuals who currently are life active members will continue as active members but no new life memberships will be permitted.

New Section 2 (G). Expands the classification of affiliate members to permit individuals recommended by a component society approved by Council to be affiliate members.

Section 2 (I), formerly 2 (J). Permits the Council to charge dues to corporate members. The possibility of corporate membership exists due to the insurance and corporate laws of Ohio.

This is a clarification. Both corporate members and retired members must be members of their component societies in order to qualify for membership in this association.

Section 6. Disciplinary Procedure. The proposed changes in this section preserve the option of filing an original disciplinary action with the Executive Director of the OSMA. However, the section makes clear that complaints in most cases should be filed with the component society, and allows the OSMA Grievance Committee, after investigating the

charges and shall also furnish to each member of the Council a copy thereof. Within thirty (30) days thereafter, the Council shall fix a time and place for a hearing on said charges and the Executive Director shall serve prompt written notice of such time and place upon the accused member and shall also furnish to each member of the Council a copy of such notice. Such hearing shall be held as soon as practicable but in no event sooner than twenty (20) days, or later than sixty (60) days, after the date of service of such notice upon the accused member. Service upon the accused of a copy of such charges or of such written notice, or both, may be made by delivering the same personally to the accused, or by sending the same both by registered mail and by regular mail addressed to the accused at his usual place of residence. At the hearing upon such charges the accused shall be afforded full opportunity to be heard in his own defense, to be represented by legal counsel of his own choosing, to cross-examine the witnesses who testify against him, and to examine witnesses and offer evidence in his own behalf. The hearing shall be held and conducted in such manner as to ascertain all the facts fairly to the accused and this Association without requiring compliance with those formal or technical rules and requirements which ordinarily pertain to judicial proceedings.

Failure of the accused to appear or be represented at the hearing may be considered prima facie evidence of the truth of the charges.

A record shall be made of such hearing, and at the request of either the accused member or the Council, the Executive Director shall cause a transcript to be made of the proceedings and evidence and shall furnish to the accused member upon request a copy of such record without charge to the accused member. Following the conclusion of the evidence, the Council shall hear arguments of the parties and their counsel and may permit or require the filing of briefs.

The accused member may appeal the decision of Council (A) COUNCIL, UPON RECEIVING A WRITTEN CHARGE AS SET FORTH ABOVE, SHALL REFER THE REQUEST TO A STANDING OR AD HOC GRIEVANCE COMMITTEE. IF THE COMMITTEE, AFTER REVIEWING THE CHARGES, CONCLUDES THAT AN INVESTIGATION IS WARRANTED, IT SHALL CONDUCT AN INVESTIGATION. THE COMMITTEE SHALL PROCEED WITH THE INVESTIGATION IN A PROMPT MANNER. THE MEMBER SHALL BE NOTIFIED THAT AN INVESTIGATION IS BEING CONDUCTED AND SHALL BE GIVEN AN OPPORTUNITY TO PROVIDE INFORMATION IN A MANNER AND UPON SUCH TERMS AS THE COMMITTEE DEEMS APPROPRIATE. THE COMMITTEE MAY, BUT IS NOT OBLIGATED TO, CONDUCT INTERVIEWS WITH PERSONS INVOLVED. SUCH INVESTIGATION SHALL NOT CONSTITUTE A "HEARING" AS THAT TERM IS USED IN THESE BYLAWS. THE COMMITTEE SHALL CONSIDER THE FINDINGS OF THE INVESTIGATION AND DETERMINE WHETHER DISCIPLINARY ACTION IS ADVISABLE. THE COMMITTEE MAY, IN ITS DISCRETION, PROCEED FORWARD WITH THE DISCIPLINARY ACTION, DISMISS THE CHARGES, OR REFER THE CHARGES TO THE APPROPRIATE COMPONENT SOCIETY FOR HANDLING.

(B) IF THE GRIEVANCE COMMITTEE DETERMINES THAT DISCIPLINARY ACTION IS ADVISABLE, IT SHALL DIRECT THE EXECUTIVE DIRECTOR TO PROVIDE NOTICE TO THE MEMBER. THE NOTICE SHALL STATE THE ACTION PROPOSED TO BE TAKEN AGAINST THE MEMBER, THE REASONS FOR THE ACTION, THE RIGHT OF THE MEMBER TO REQUEST A HEARING WITHIN 30 DAYS OF THE DATE OF THE NOTICE, AND A SUMMARY OF THE RIGHTS AND PROCEDURES TO BE FOLLOWED DURING THE HEARING. THE MEMBER SHALL HAVE 30 DAYS FOLLOWING THE DATE OF THE NOTICE OF SUCH ACTION TO REQUEST A HEARING. THE REQUEST SHALL BE IN WRITING ADDRESSED TO THE EXECUTIVE DIRECTOR.

IF THE MEMBER DOES NOT REQUEST A HEARING IN THE TIME AND MANNER DESCRIBED, THE MEMBER SHALL BE DEEMED TO HAVE WAIVED ANY RIGHT TO A HEARING AND TO HAVE ACCEPTED THE RECOMMENDATION INVOLVED. THE WRITTEN INVESTIGATION REPORT SHALL BE FORWARDED TO THE STANDING OR AD HOC COMMITTEE ON JUDICIAL AND PROFESSIONAL RELATIONS WHICH SHALL DETERMINE THE ACTION TO BE TAKEN. THE MEMBER UNDER THIS SECTION SHALL HAVE NO FURTHER RIGHTS TO HEARING OR APPEAL UNLESS THE ACTION TAKEN

complaint, to refer the matter to the component society if it is more appropriately handled at that level. Alternatively, following its investigation, the Grievance Committee may dismiss the complaint or recommend that an action be taken based upon the complaint. This process recognizes that a component society may be unable to fairly or adequately proceed through its disciplinary process in certain circumstances, while providing a mechanism to ensure that the component societies continue to play an active role in the disciplinary process. In addition, these changes reemphasize that peer review must be performed on a local level throughout Ohio.

The remainder of the changes to Chapter 1, Section 6 set forth the procedure to be followed in a disciplinary proceeding before the OSMA. These provisions establish the procedure in more detail than the current version in order to insure compliance with the qualified immunity requirements of the Health Care Quality Improvement Act of 1986. An outline of the procedures is set forth in the attached flow chart. (See page 12A of this document.)

In addition, an internal appeal to Council has been added so that any legal or procedural errors can be identified and corrected at the OSMA level. This appeal provides the accused with additional protection from bias or error, which adds an additional element of fairness to the process in the event of a challenge in Court or to the AMA.

DIFFERS FROM THE RECOMMENDATION OF THE GRIEVANCE COMMITTEE.

(C) UPON RECEIPT OF A REQUEST FOR HEARING, THE MATTER SHALL BE REFERRED TO A STANDING OR ADHOC COMMITTEE ON JUDICIAL AND PROFESSIONAL RELATIONS OR A STANDING OR AN AD HOC COMMITTEE ON PEER REVIEW WHICH SHALL APPOINT A HEARING OFFICER OR PANEL OF INDIVIDUALS TO CONDUCT THE HEARING WHO MAY BE ONE OR MORE OF ITS MEMBERS OF THE STANDING OR AD HOC COMMITTEE PROVIDED SUCH HEARING OFFICER OR PANEL MEMBERS MAY NOT BE IN DIRECT ECONOMIC COMPETITION WITH THE MEMBER. A HEARING SHALL BE SCHEDULED TO COMMENCE NOT LESS THAN 30 DAYS NOR MORE THAN 90 DAYS FROM THE DATE OF RECEIPT OF THE REQUEST FOR HEARING. THE EXECUTIVE DIRECTOR SHALL SEND THE MEMBER A NOTICE STATING THE PLACE, TIME, AND DATE OF THE HEARING AND A LIST OF THE WITNESSES, IF ANY, EXPECTED TO TESTIFY AT THE HEARING ON BEHALF OF THE GRIEVANCE COMMITTEE.

THE HEARING OFFICER OR PANEL SHALL ENDEAVOR TO ENSURE THAT ALL PARTICIPANTS IN THE HEARING HAVE A REASONABLE OPPORTUNITY TO BE HEARD AND TO PRESENT RELEVANT ORAL AND DOCUMENTARY EVIDENCE IN AN EFFICIENT AND EXPEDITIOUS MANNER, AND THAT PROPER DECORUM IS MAINTAINED. THE HEARING OFFICER OR PANEL SHALL BE ENTITLED TO DETERMINE THE ORDER OF, OR PROCEDURE FOR, PRESENTING EVIDENCE AND ARGUMENTS DURING THE HEARING AND SHALL HAVE THE AUTHORITY AND DISCRETION TO MAKE ALL RULINGS ON QUESTIONS WHICH PERTAIN TO MATTERS OF LAW, PROCEDURE OR THE ADMISSIBILITY OF EVIDENCE. IF THE HEARING OFFICER OR PANEL DETERMINES THAT EITHER SIDE IN A HEARING IS NOT PROCEEDING IN AN EFFICIENT AND EXPEDITIOUS MANNER, THE HEARING OFFICER OR PANEL MAY TAKE SUCH DISCRETIONARY ACTION AS SEEMS WARRANTED BY THE CIRCUMSTANCES.

THE HEARING OFFICER OR PANEL MAY, BUT SHALL NOT BE REQUIRED TO, ORDER THAT ORAL EVIDENCE BE TAKEN ONLY ON OATH ADMINISTERED BY ANY PERSON LAWFULLY AUTHORIZED TO ADMINISTER SUCH OATHS. JUDICIAL RULES OF EVIDENCE AND PROCEDURE RELATING TO THE CONDUCT OF THE HEARING, THE EXAMINATION OF WITNESSES, AND THE PRESENTATION OF EVIDENCE SHALL NOT APPLY TO A HEARING CONDUCTED UNDER THESE BYLAWS. ANY RELEVANT EVIDENCE, INCLUDING HEARSAY, SHALL BE ADMITTED IF IT IS THE SORT OF EVIDENCE UPON WHICH REASONABLE PEOPLE ARE ACCUSTOMED TO RELY IN THE CONDUCT OF SERIOUS AFFAIRS, REGARDLESS OF THE ADMISSIBILITY OF SUCH EVIDENCE IN THE COURT OF LAW. THE HEARING OFFICER OR PANEL MAY INTERROGATE THE WITNESSES OR CALL ADDITIONAL WITNESSES IF THE HEARING OFFICER OR PANEL DEEMS SUCH ACTION APPROPRIATE.

(D) BOTH THE MEMBER AND THE GRIEVANCE COMMITTEE HAVE THE RIGHT TO BE REPRESENTED IN ANY PHASE OF THE HEARING OR PRELIMINARY PROCEDURES BY AN ATTORNEY AT LAW OR BY ANY OTHER PERSON OF THAT PARTY'S CHOICE; TO HAVE A RECORD MADE OF THE PROCEEDINGS, COPIES OF WHICH MAY BE OBTAINED BY THE MEMBER UPON PAYMENT OF ANY REASONABLE CHARGES ASSOCIATED WITH THE PREPARATION THEREOF; THE GRIEVANCE COMMITTEE, THE ACCUSED, LEGAL COUNSEL FOR THE ACCUSED OR THE GRIEVANCE COMMITTEE OR ANY OTHER PERSON OF EITHER PARTY'S CHOICE SHALL HAVE THE RIGHT TO CALL, EXAMINE, CROSS-EXAMINE, AND IMPEACH WITNESSES; TO PRESENT EVIDENCE DETERMINED TO BE RELEVANT BY THE HEARING OFFICER, REGARDLESS OF ITS ADMISSIBILITY IN A COURT OF LAW; AND TO SUBMIT A WRITTEN STATEMENT AT THE CLOSE OF THE HEARING.

UNLESS OTHERWISE DETERMINED FOR GOOD CAUSE, THE GRIEVANCE COMMITTEE SHALL HAVE THE INITIAL DUTY TO PRESENT EVIDENCE FOR EACH CASE OR ISSUE IN SUPPORT OF THE PROPOSED ACTION

In some cases, the use of a panel will allow more flexibility than only a hearing officer and will ensure fairness.

There will be less likelihood of bias if the adjudicator (s) are not in competition with the member.

OR RECOMMENDATION. THE MEMBER SHALL BE OBLIGATED TO PRESENT EVIDENCE IN RESPONSE. THROUGHOUT THE HEARING, THE GRIEVANCE COMMITTEE SHALL BEAR THE BURDEN OF PERSUADING THE HEARING OFFICER OR PANEL, BY A PREPONDERANCE OF THE EVIDENCE, THAT THE ACTION OR RECOMMENDATION IS REASONABLE AND WARRANTED.

FAILURE WITHOUT GOOD CAUSE OF THE MEMBER TO PERSONALLY ATTEND THE HEARING SHALL BE DEEMED TO CONSTITUTE ACCEPTANCE OF THE DISCIPLINARY ACTION INVOLVED, AND A WAIVER OF THE RIGHT TO A HEARING. POSTPONEMENTS AND EXTENSIONS OF THE TIME BEYOND THE TIME FOR HEARING PERMITTED IN THESE BYLAWS MAY BE PERMITTED BY THE HEARING OFFICER OR PANEL, WITHIN HIS/HER/THEIR DISCRETION ON A SHOWING OF GOOD CAUSE.

(E) THE RECOMMENDATION OF THE HEARING OFFICER OR PANEL SHALL BE BASED ON THE EVIDENCE INTRODUCED AT THE HEARING, INCLUDING ALL LOGICAL AND REASONABLE INFERENCES FROM THE EVIDENCE AND THE TESTIMONY. WITHIN 30 DAYS AFTER THE FINAL ADJOURNMENT OF THE HEARING, THE HEARING OFFICER OR PANEL SHALL RENDER A RECOMMENDATION WHICH SHALL BE ACCOMPANIED BY A REPORT IN WRITING STATING THE REASONS FOR THE RECOMMENDATION. THE REPORT AND RECOMMENDATION SHALL BE DELIVERED TO THE COMMITTEE ON JUDICIAL AND PROFESSIONAL RELATIONS AND TO THE MEMBER, AT ITS NEXT REGULAR MEETING AFTER RECEIPT OF THE REPORT AND RECOMMENDATION, OR AS SOON THEREAFTER AS IS PRACTICABLE. THE COMMITTEE ON JUDICIAL AND PROFESSIONAL RELATIONS SHALL CONSIDER THE REPORT, RECOMMENDATION, AND ANY OTHER RELEVANT INFORMATION. IT SHALL THEN MAKE A FINAL DECISION REGARDING THE PROPOSED DISCIPLINARY ACTION, AND NOTIFY COUNCIL OF ITS DECISION. FOLLOWING THE DECISION, THE EXECUTIVE DIRECTOR SHALL FORWARD TO THE MEMBER THE WRITTEN DECISION OF THE COMMITTEE, INCLUDING A STATEMENT OF THE BASIS FOR THE DECISION.

(F) ANY MEMBER AGAINST WHOM DISCIPLINARY ACTION HAS BEEN TAKEN PURSUANT TO THESE BYLAWS SHALL HAVE THE RIGHT OF APPEAL TO COUNCIL. SUCH APPEAL MUST BE COMMENCED BY A WRITTEN NOTICE DIRECTED TO THE EXECUTIVE DIRECTOR WITHIN 30 DAYS AFTER THE DATE ON WHICH THE NOTICE OF FINAL DECISION WAS MAILED TO THE MEMBER. THE MEMBER ASSERTING A RIGHT TO APPEAL SHALL BEAR ALL EXPENSES ASSOCIATED WITH PROVIDING A COPY OF THE RECORD FROM THE DISCIPLINARY PROCEEDING AND FOR PRODUCTION OF ANY RECORD ASSOCIATED WITH THE APPEAL.

Standard judicial procedure requires the appellant to bear the costs of going forward with an appeal. A member who asserts the right to appeal should be responsible for financing the costs of the appeal.

UPON RECEIPT OF NOTICE OF APPEAL, COUNCIL SHALL SERVE AS THE APPELLATE PANEL. THE MEMBER APPEALING SHALL SUBMIT A WRITTEN STATEMENT DISCUSSING THE RELEVANT FACTS AND ISSUES, WITHIN 20 DAYS FOLLOWING THIS SUBMISSION OF THE MEMBERS' WRITTEN STATEMENT. THE GRIEVANCE COMMITTEE MAY SUBMIT A WRITTEN RESPONSE TO THAT STATEMENT. THE MEMBER MAY SUBMIT A WRITTEN REPLY WITHIN TEN DAYS FOLLOWING THE SUBMISSION OF THE GRIEVANCE COMMITTEE'S RESPONSE.

THE COUNCIL MAY, UPON ITS OWN MOTION OR REQUEST BY THE MEMBER OR GRIEVANCE COMMITTEE, SCHEDULE ORAL ARGUMENTS UPON THE ISSUES RAISED IN THE APPEAL. THE ORAL ARGUMENTS, IF SCHEDULED, SHALL BE HELD WITHIN 20 DAYS FOLLOWING THE SUBMISSION OF THE FINAL WRITTEN BRIEF.

THE COUNCIL SHALL, WITHIN 20 DAYS AFTER THE ORAL ARGUMENTS OR THE FINAL WRITTEN SUBMISSION IF ORAL ARGUMENTS ARE NOT CONDUCTED, RENDER A WRITTEN OPINION SETTING FORTH ITS DECISION WHETHER TO ACCEPT, REJECT OR MODIFY THE DECISION OF THE JUDICIAL AND PROFESSIONAL RELATIONS COMMITTEE STATING THE BASIS FOR ITS DECISION. THE EXECUTIVE DIRECTOR SHALL FORWARD

(G) THE ACCUSED MEMBER MAY APPEAL THE DECISION OF THE COUNCIL on questions of law and procedure, but not of fact, to the Judicial Council of the AMA by filing a notice of appeal with the Judicial Council within thirty days of the decision of Council, such appeal to be governed by the rules and regulations of the Judicial Council. ~~The decision of Council shall be final pending an appeal to the Judicial Council.~~

(H) AFTER FINAL ACTION HAS BEEN TAKEN PURSUANT TO SUBDIVISION (B) OR (E) OF THIS SECTION, AND THE MEMBER HAS EITHER WAIVED OR EXHAUSTED THE RIGHT TO APPEAL TO COUNCIL AND THE RIGHT TO APPEAL TO THE AMA, THE EXECUTIVE DIRECTOR SHALL REPORT THE ACTION TO STATE AND FEDERAL AUTHORITIES AS REQUIRED BY OHIO REVISED CODE 4731.224, AND THE HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986 (PUBLIC LAW 99-660, TITLE IV AND 45 CFR PART 60), AND OTHER APPLICABLE FEDERAL AND STATE LAWS.

Section 76. Limitation of Liability. No member, AGENT or employee serving on a utilization committee, a peer review or professional standards review committee, ~~which includes~~ ING ANY PERSON participation ~~ING in the context of this~~ THE ~~PROCESS SET FORTH IN THE disciplinary Chapter; of this Association shall be deemed liable in damages to any person for any action taken or recommendation made within the scope of the functions of said committee, if such committee member, AGENT or employee acts without malice and in the reasonable belief that such action or recommendation is warranted by the facts known to him~~ THE PERSON after reasonable effort to obtain the facts of the matter as to which such action is taken or recommendation is made. NO PERSON AGAINST WHOM DISCIPLINARY ACTION IS INSTITUTED PURSUANT TO THE DISCIPLINARY CHAPTER OF THESE BYLAWS SHALL HAVE ANY CLAIM OR CAUSE OF ACTION AGAINST THIS ASSOCIATION, OR AGAINST ANY OFFICER, COUNCILOR, MEMBER, AGENT OR EMPLOYEE OF THIS ASSOCIATION, BY REASON OF THE INSTITUTION, PROSECUTION, OR DISPOSITION OF SUCH CHARGES OR THE HEARING OR CONSIDERATION THEREOF.

CHAPTER 2 DUES AND ASSESSMENTS

Section 1. Determination of Dues. The annual dues and assessments of Active Members ~~and Associate Members~~ of this Association shall be determined by the House of Delegates, and shall be levied per capita on such members. They shall be payable before January 1; of the calendar year for which such dues are levied. The dues and assessments ~~shall be collected by the designated officer of each component society and~~ SHALL BE COLLECTED BY THE DESIGNATED OFFICER OF EACH COMPONENT SOCIETY UNLESS THE COMPONENT SOCIETY ELECTS TO HAVE OSMA COLLECT SAID DUES AND ASSESSMENTS AND shall be forwarded to the headquarters of this Association, together with such data as shall be required by this Association NOT LATER THAN JANUARY 1 for its own record. of such society's officers and membership.

The Council of this Association shall have the authority to promulgate regulations governing the amount of annual dues and assessments of all classifications of members other than Active ~~and Associate~~. A physician who is not engaged in active practice because of disability ~~or the infirmities of age~~ and who was a member in good standing of this Association at the time of ~~his retirement from active practice shall~~ THE ~~DISABILITY MAY~~ be exempt from the payment of dues and assessments in this Association, provided ~~he~~ ANY requests ~~FOR~~ such exemption ~~FROM DUES AND ASSESSMENTS and such request~~ is approved in writing by the secretary of ~~his~~ THE MEMBER'S component society.

This addition allows for flexibility should there be any changes in federal or state law.

As with the current version of the section, the proposed section tracks the language of the peer review immunity statute. R.C. 2305.25. However, the term "agent" has been inserted to clarify that any consultant or outside hearing examiner, who is not a member of one of the peer review committees or not a member of the OSMA but is needed in the disciplinary process, is also covered by the immunity provided by this section.

The additional language proposed to be inserted at the end of this section serves the purpose of strengthening the protection provided by this section. This language prohibits legal actions against the OSMA or any committee or participant in the disciplinary process which is based solely on disciplinary action having been taken.

Section 1. Determination of Dues. The original change proposed by the Council, deleted the reference of the associate members because that classification was proposed deleted in the constitution. Resolutions Committee No. 4 added the language permitting the OSMA to collect the dues and assessments for the county society.

A member of this Association for whom payment of ~~his~~ THE MEMBER'S regular dues ~~in this Association~~ constitutes a financial hardship may SUBMIT A request TO the Council of this Association for an adjustment of dues. Such request shall be in writing, signed by ~~such~~ THE member and filed with the secretary of ~~such~~ THE member's component society. If such society, or the council of such society, finds that payment by ~~such~~ THE member of ~~his~~ regular dues in this Association shall constitute a financial hardship and certifies ~~such~~ THE finding to the Council of this Association, the Council of this Association will make ~~such~~ AN adjustment of ~~his~~ THE MEMBER'S OSMA dues for such period of time, and subject to such conditions, as ~~such~~ OSMA Council may deem appropriate and advisable.

Section 2. Receipt of Dues, Qualifying Membership. The record of payment of dues and assessments on file in the offices of this Association shall be evidence of the fact of payment by a member and of ~~his~~ THAT MEMBER'S right to attend all meetings of the Association. ~~and to participate in all the scientific proceedings of the Annual Meeting.~~

Section 3. Arrears In Membership. A member of this Association whose dues and assessments in this Association shall not have been paid ~~to the secretary of his component society~~ on or before JANUARY 1 of any year shall be deemed delinquent from JANUARY 1 of such year and until such dues and assessments have been paid.

Section 4. Penalty for Failure to Remit. Any component society which fails to forward to the headquarters of this Association on or before the thirtieth (30th) day preceding the Annual Meeting such dues and assessments of this Association as the society may have collected shall be subject to the suspension of all its rights and privileges under its charter, ~~in which case~~ AND none of its members or delegates shall be permitted to participate in any of the proceedings of this Association or of the House of Delegates.

Section 5. Exemption from Dues and Assessments. The provisions of Section 2 and 3 of this Chapter shall not apply to members exempted from the payment of dues and assessments, or to members whose dues and assessments are waived.

CHAPTER 3 ANNUAL MEETING

Section 1. Functions of Annual Meeting. The Annual Meeting of the Association will be held as provided in Article V of the Constitution. ~~This shall encompass the Scientific Assembly, the House of Delegates meetings and such other functions as may be determined by the Council.~~

Section 2. Registration. Each member in attendance at the Annual Meeting shall register, after ~~his~~ THE MEMBER'S status as a member in good standing has been verified by reference to the records of this Association. ~~The name of a physician upon the membership roster of this Association shall be prima facie evidence of his right to register.~~

No member or delegate shall take part in any of the proceedings of the Annual Meeting until ~~he~~ THAT MEMBER OR DELEGATE has registered.

Section 3. Scientific Program. The Scientific Assembly shall meet in such general sessions and such section sessions during the Annual Meeting as may be determined by the Committee on Education with the approval of the Council.

Section 4. Section Officers. Each section shall elect a chairman and a secretary to serve until their successors are elected. They shall serve as ex-officio members of the Committee on Education provided for in Section 4 of Chapter 9 of these Bylaws.

If for any reason a section shall fail to elect section officers at a section session held during the Annual Meeting, such officers shall be appointed by the Council at its first meeting following the close of the Annual Meeting.

Section 5. Section Sessions. Each section authorized by the Council shall hold its

Section 2. Deletes reference to scientific proceedings at the Annual Meeting.

Chapter 3. The proposed revisions of this chapter permit the Annual Meeting to be structured as the membership desires. The Annual Meeting no longer contains scientific sections or sessions and those references are deleted. This proposed change does not eliminate or limit the possibilities of the structure of the Annual Meeting.

session or sessions at times determined by the Council but no section session shall be held at the same time as a general session.

Section 76. Section Rules. Rules adopted by a section must not be in conflict with the Constitution and Bylaws of this Association and must be approved by the Council before becoming effective.

Section 67. Acceptance of Papers. The papers and discussions in section meetings shall be limited to scientific subjects. No paper shall be presented before a section unless an abstract of such paper, containing not less than thirty (30) and not more than one hundred and fifty (150) words, be in the hands of the Committee on Education at least thirty (30) days before the first day of the Annual Meeting.

Section 8. Time Limit of Papers. The Committee on Education shall each year fix a time limit for the delivery of each paper.

Section 9. Papers shall be the Property of the Association. All papers read before this Association shall be its property and immediately after being read shall be deposited with the secretary of the section, if read before a section, or with the Executive Director, if read before a general session. Unless express consent of the Council is first obtained, no member shall cause a paper read before this Association, or any part, abstract or summary thereof, to be published elsewhere prior to publication in the official Journal of this Association; and each guest speaker invited to read or deliver a paper on a medical or scientific subject shall be expected to agree, at the time of his THE GUEST SPEAKER'S acceptance of such invitation, to refrain from causing such paper to be published elsewhere prior to publication in such Journal. These papers shall be released to the author by the Editor of The Journal if he THE AUTHOR has not stated, within a period of six (6) months after submission, his intent to publish them THE PAPER.

CHAPTER 4 THE HOUSE OF DELEGATES

Section 1. Meetings of the House of Delegates. The House of Delegates shall meet annually at the time and place of the Annual Meeting of this Association. All sessions of the House of Delegates shall be ARE open to all members in good standing of this Association.

Section 2. Ratio of Representation. Each component society shall be entitled to one delegate in the House of Delegates for each one hundred (100) Active, ASSOCIATE, MEMBERS IN TRAINING AND RETIRED MEMBERS ~~Members, Associate Members, and Members in Training, or fraction thereof,~~ in good standing in this Association; provided, however, that each component society shall be entitled to at least one delegate and one alternate delegate. IF THE TOTAL NUMBER OF THESE MEMBERS OF THE COMPONENT SOCIETY IS NOT EVENLY DIVISIBLE BY ONE HUNDRED (100), THAT COMPONENT SOCIETY SHALL BE ENTITLED TO ONE ADDITIONAL DELEGATE IN THE HOUSE OF DELEGATES. The names of such delegates and alternate delegates shall be submitted to the headquarters of this Association at least ~~thirty (30)~~ SIXTY (60) days prior to the first day of the meeting of the House of Delegates.

In case a delegate or alternate delegate of a component society is unable to serve, the president or secretary of such society may at any time certify to the ~~Chairman~~ CHAIR of the Committee on Credentials the name of an ~~Active~~ VOTING Member ~~or Member in Training~~ in good standing to serve in the place of such absent delegate or absent alternate delegate. The Committee on Credentials shall rule on the eligibility of such certified individual or individuals to act in the place ~~and stead~~ of such absent delegate or alternate delegate.

Section 3. Representation of Medical Specialties. All primary medical specialties listed by the American Board of Medical Specialties are eligible to apply for representation in the House of Delegates. ~~If to be eligible, the specialty society or societies in the section initially must have HAS 50% 60% of their physicians as members of the OSMa. At the end of its third year of representation, its percentage of OSMa membership must equal the percentage of the total physician population in Ohio who are members of~~

Section 2. The Resolutions committee modified the language to clarify the basis for representation as active, associate, members in training and retired members. Section 2 increases the number of days from 30 to 60 that delegate and alternate delegate lists be submitted to the OSMa for processing. The section still permits the president or secretary of such society to certify another individual as a delegate or alternate delegate during the meeting, subject to review of the committee on credentials.

Section 3. After much discussion, Resolutions Committee No. 4 rejected the proposal to maintain a specific percentage OSMa membership requirement for statewide medical specialty societies to participate at the OSMa House of Delegates. The committee

OSMA, calculated as of January 31, each year. If for 3 consecutive years thereafter this percentage is not maintained, then delegate status is terminated.

concluded that the requirement should be eliminated. The Resolutions committee believes that the OSMA should work with all medical specialty societies and that this goal would be easier to achieve if the medical specialty societies are an integral part of the House of Delegates. The committee believes that the integration of all medical specialty societies will be greatly aided by simply inviting them to participate in the House of Delegates deliberations. The medical specialty societies will have the right to substitute delegates.

The Council also deliberated this issue at its November meeting and failed to reach a consensus on this proposed revision.

A Medical Specialty ~~Section~~ SOCIETY seeking representation shall apply to the Council. The Council shall consider these applications and then recommend to the House of Delegates whether the specialty society qualifies for representation.

Each recognized Medical Specialty ~~Section~~ SOCIETY shall have one delegate and ONE alternate DELEGATE who must be VOTING Members of the Ohio State Medical Association. Each specialty ~~section~~ SOCIETY will certify to the Association at least 60 days prior to the Annual Meeting both the names of its delegate and alternate, and its membership certification as required by ~~subsection (b)~~ above. IN CASE A DELEGATE OR ALTERNATE DELEGATE IS UNABLE TO SERVE, THE PRESIDENT OF THE RECOGNIZED MEDICAL SPECIALTY SOCIETY MAY AT ANY TIME CERTIFY TO THE CHAIR OF THE COMMITTEE ON CREDENTIALS THE NAME OF A VOTING MEMBER OF THE ASSOCIATION TO SERVE IN PLACE OF THE ABSENT DELEGATE OR ABSENT ALTERNATE DELEGATE. THE COMMITTEE ON CREDENTIALS SHALL RULE ON THE ELIGIBILITY OF SUCH CERTIFIED INDIVIDUAL OR INDIVIDUALS TO ACT IN THE PLACE OF SUCH ABSENT DELEGATE OR ALTERNATE DELEGATE. A Medical Specialty ~~Section~~ SOCIETY delegate shall have all rights, privileges and duties as other delegates. The delegate will be seated in the House of Delegates with the Councilor District in which ~~his/her~~ THAT DELEGATE'S county medical society is represented.

~~Failure to comply with Section 3, Chapter 4 shall result in loss of representation. That determination shall be made by the Council, with appeal provided to the House of Delegates.~~

Section 4. Resident Section. The Resident Section shall have one delegate and one alternate delegate who must be Members in Training of the OSMA. The Resident Physician Section's delegates shall have all the rights, privileges, and duties of other delegates. The delegate will be seated in the House of Delegates with THE Councilor District in which ~~his/her~~ THAT DELEGATE'S county medical society is represented.

Section 5. Representative of Hospital Medical Staff Section. The Hospital Medical Staff Section shall have one delegate and alternate delegate who must be ~~Active~~ VOTING Members of the Ohio State Medical Association. In case a delegate or alternate delegate is unable to serve, the ~~Chairman~~ CHAIR of the Section may at any time certify to the ~~Chairman~~ CHAIR of the Committee on Credentials the name of an ~~Active~~ VOTING Member of the Association to serve in place of the absent delegate or absent alternate delegate. The Committee on Credentials shall rule on the eligibility of such certified individual or individuals to act in the place ~~and stand~~ of such absent delegate or alternate delegate. The Hospital Medical Staff Section delegate shall have all rights, privileges and duties of other delegates. The delegate will be seated in the House of Delegates with the Councilor District in which ~~his/her~~ THAT DELEGATE'S county medical society is represented.

SECTION 6. MEDICAL STUDENT SECTION. THE MEDICAL STUDENT SECTION SHALL HAVE ONE DELEGATE AND ONE ALTERNATE DELEGATE SELECTED FROM EACH OF THE SIX MEDICAL COLLEGES AND THE ONE

Chapter 4, Section 6 - Permits one delegate and alternate delegate from each of the six medical schools and one from the Osteo-

OSTEOPATHIC MEDICAL COLLEGE IN THE STATE OF OHIO PURSUANT TO THE MEDICAL STUDENT SECTION BYLAWS. THE MEDICAL STUDENT SECTION DELEGATES SHALL HAVE ALL THE RIGHTS, PRIVILEGES AND DUTIES OF OTHER DELEGATES. THE SEVEN (7) DELEGATES WILL BE SEATED IN THE HOUSE OF DELEGATES AS A SEPARATE SECTION WHICH SHALL BE SEATED AS AN ADDITIONAL DISTRICT.

Section 67. Quorum. A majority of registered delegates and officers of this Association shall constitute a quorum.

Section 78. Committees of the House of Delegates. For the purpose of expediting proceedings the President shall appoint from the roster of delegates the following reference committees: ~~Committee on President's Address~~; Committees on Resolutions, to which shall be referred all resolutions (except those of an ethical nature involving the professional relations of individual physicians or groups of physicians); Committee on Credentials; and other committees considered necessary by the President.

The President shall appoint from the roster of alternate delegates the Committee on Tellers and Judges of Election.

Section 89. Delegates to the American Medical Association. The House of Delegates shall elect representatives to the House of Delegates of the American Medical Association in accordance with the constitution and bylaws of that body, except for one alternate delegate, who shall be elected by the Medical Student Section in accordance with the constitution and bylaws of this Association and the bylaws of the Medical Student Section.

Section 910. Councilor Districts. The House of Delegates shall establish Councilor Districts. The districts shall comprise one or more contiguous counties. A district society may be organized in any of the Councilor Districts to meet at such time or times as such society may fix.

Section 1011. Special Committees. Any Voting Member ~~who is in good standing in~~ OF this Association may be appointed to serve on any committee created for a special purpose. All members of committees who are not members of the House of Delegates shall have the right to present their reports to the House in person and to participate in the debate thereon, but shall not have the right to vote.

Section 1112. Resolutions. Except as otherwise provided, ~~under Section 12,~~ every resolution to be presented to the House of Delegates for action shall be filed with the Executive Director of the Association at least sixty (60) days prior to the first day of the meeting at which action on such resolution is proposed to be taken; and promptly upon the filing of any such resolution the Executive Director shall prepare and transmit a copy thereof to each member of the House of Delegates. Each resolution which, if adopted, would require expenditure of funds by the Association, shall have attached; a statement of the amount of the estimated annual expenditure. The Executive Director shall cause to be published in ~~The Journal in~~ advance of such meeting of the House of Delegates such resolutions as the President or the Council may designate.

No resolution may be presented or introduced at any meeting of the House of Delegates, unless the foregoing requirements for filing and transmittal shall have been complied with, or unless such compliance shall have been waived under Section 12; OR by a Special Committee on Emergency Resolutions named to decide whether late submission was justified. LATE SUBMISSION IS ONLY JUSTIFIED WHEN EVENTS GIVING RISE TO THE RESOLUTION OCCUR AFTER THE FILING DEADLINE FOR RESOLUTIONS. This special committee shall consist of the chairmen of the several resolution committees. If a majority of the members of the Special Committee on Emergency Resolutions vote favorably for waiving the filing and transmittal requirement, then such resolution shall be presented to the House of Delegates at its opening session. All resolutions presented subsequent to the 60-day filing date prior to the opening session of the House of Delegates shall be submitted by their sponsors to the committee no less than 12 hours prior to the opening session of the House of Delegates. IF THE COMMITTEE VOTES UNFAVORABLY, THE HOUSE MAY OVERRIDE THE COMMITTEE'S RECOMMENDATION BY AN AFFIRMATIVE

pathic Medical College.

New Section 12 deletes a specific reference to "The Journal" but does not eliminate the publication requirement.

The new language identifies the justification for submission of emergency resolutions and clarifies the authority of the House to override the committee's recommendation.

No consideration may be given, or any action taken, by the Committee on Resolutions or by the House of Delegates, with respect to any resolution unless such resolution ~~shall have been~~ IS presented or introduced at the opening session of the meeting of the House of Delegates; ~~provided;~~ However, ~~that~~ a resolution dealing with an event or development occurring too late to permit the introduction of any such resolution at the opening session may be introduced at a later session with the consent of at least four-fifths (4/5) of the delegates present; ~~and~~ Upon its introduction, such resolution shall be referred to the Committee on Resolutions for consideration and report; ~~and, provided further, that~~ The Committee on Resolutions shall have the right to amend any SUCH resolution presented or introduced, or to draft a composite or substitute resolution embracing the same subject matter as ~~that contained in a~~ THE resolution or resolutions ~~presented or~~ introduced, and to submit such amended, composite or substitute resolution for adoption by the House of Delegates; ~~and,~~ The House of Delegates shall have the right to adopt any such amended, composite or substitute resolution.

Any resolution adopted by the House of Delegates ~~in 1979 and thereafter~~ will become null, void and of no effect if not re-proposed and re-adopted within four years from the effective date of the adoption of the Resolution. Within the fourth year of their effective date, the House of Delegates will be notified ~~by January 31 in writing~~ of those resolutions subject to re-adoption at the Annual Meeting at which they will be considered.

Section 1213. Hospital Medical Staff Section Resolutions. A maximum of five resolutions, directly related to issues of concern to physicians on Hospital Medical Staffs and matters of immediate importance, adopted by and presented from the business meeting of the hospital medical staff section representative assembly, as provided in their bylaws, may be presented for consideration by the ~~h~~House of ~~d~~Delegates at any time before the opening of the ~~h~~House of ~~d~~Delegates. All other resolutions adopted by and presented from the business meeting of the Representative Assembly of the Hospital Medical Staff Section shall be submitted in report form to the House of Delegates at the Annual Meeting of the House of Delegates for THE purpose of filing.

Section 1314. Order of Business. ~~The following shall be the order of business for the opening and final sessions of the House of Delegates:~~ THE ORDER OF BUSINESS OF THE HOUSE OF DELEGATES SHALL BE ACCORDING TO THE STURGIS STANDARD CODE OF PARLIAMENTARY PROCEDURE.

Chapter 4, Section 14 - Eliminates the statutory listing of the Order of Business. The House may modify the Sturges Standard Order of Business.

A. Opening Session:

- ~~1. Call to order by the President.~~
- ~~2. Report of Committee on Credentials.~~
- ~~3. Consideration of minutes of last Annual Meeting and of minutes of any special meeting of the House of Delegates held since the last Annual Meeting.~~
- ~~4. Introduction of special guests.~~
- ~~5. Appointment of Reference Committees by the President.~~
- ~~6. Election of Committee on Nominations.~~
- ~~7. Report of Special and Standing Committees.~~
- ~~8. President's Address.~~
- ~~9. Introduction of Presidents of other State Societies~~
- ~~10. President-Elect's Address.~~
- ~~11. Introduction of Resolutions.~~
- ~~12. Miscellaneous business.~~

B. Final Session:

1. ~~Report of Committee on Credentials.~~
2. ~~Election of President-Elect.~~
3. ~~Report of Committee on Nominations; and election of other officers.~~
4. ~~Reports of Reference Committees.~~
5. ~~Miscellaneous business.~~
6. ~~Installation of officers.~~
7. ~~Unfinished business.~~
8. ~~Adjournment.~~

The order of business may be modified for any session by the presiding officer with consent of the House of Delegates.

CHAPTER 5 NOMINATION AND ELECTION OF OFFICERS

Section 1. Committee on Nominations. On the first day of the Annual Meeting the House of Delegates shall elect a Committee on Nominations consisting of one delegate from each Councilor District. The ~~chairmanship~~ CHAIR of the Committee on Nominations shall be rotated in numerical order annually among the Councilor District representatives on such Committee. The Committee on Nominations shall report to the House of Delegates a ticket containing the name of one or more members for each of the offices to be filled at that Annual Meeting, except that of President-Elect. Prior to selecting a ticket the Committee shall hold hearings which shall be open to all members in good standing of this Association. Any member in good standing shall have the opportunity to appear before the Committee regarding any proposed candidate. The Committee may request an interview with any proposed candidate or with any member concerning such proposed candidate's qualifications. Each nominee must have a majority vote of the Committee in order to be placed on the ticket for presentation to the House of Delegates. Each nominee for Councilor must be a resident of the Councilor District for which ~~he~~ THAT COUNCILOR is nominated. Delegates and Alternate Delegates to the American Medical Association shall be elected at large.

Section 2. Eligibility for Reelection of Officers, Delegates and Alternate Delegates to the American Medical Association. No Past President of this Association shall be eligible for election as President-Elect. No Secretary-Treasurer shall serve for more than two consecutive terms. No Councilor shall serve in such capacity for more than three consecutive terms. Any officer originally elected to serve a year or less of an unexpired term shall not be regarded thereby as having served a term. Nothing in these Bylaws shall be construed as forbidding later reelection to any office, other than that of President or President-Elect, after an interruption in consecutive service.

Section 3. Nomination of President-Elect. Nominations for the office of President-Elect shall be made from the floor of the House of Delegates; provided, however, that only those candidates may be nominated whose names have been filed with the Executive Director ~~at the time and in the manner hereinafter~~ AS HEREIN provided, unless compliance with such requirements shall be waived, ~~as hereinafter provided.~~ The name of a candidate for the office of President-Elect must be filed with the Executive Director of the Association at least sixty (60) days prior to the meeting of the House of Delegates at which the election is to take place. ~~Promptly~~ Upon the filing of such candidate's name, the Executive Director shall prepare and transmit PROMPTLY this information to each member of the House of Delegates. ~~No nomination for President-Elect may be presented at any meeting of the House unless the foregoing requirements of filing and transmittal have been complied with or unless such compliance shall have been~~ COMPLIANCE WITH THE FILING AND TRANSMITTAL REQUIREMENTS MAY BE waived or dispensed with by a vote of at least two-thirds (2/3) of the delegates present at the opening session of such meeting. The Executive

Director shall cause to be published in ~~The Journal~~ in advance of such meeting of the House of Delegates biographical information on all candidates meeting the requirements of filing and transmittal.

Section 4. Nomination and Election of District Councilors. Nominations for the office of District Councilor shall be made ~~from the floor of AT~~ the House of Delegates; ~~provided,~~ However, that only those candidates may be nominated whose names have been filed with the Executive Director at the time and in the manner hereinafter provided; ~~unless compliance with such requirement shall be waived as hereinafter provided; that the name or names of a candidate or candidates for the office of Councilor must be filed by the caucus of that district's delegates with the Executive Director of the Association prior to the opening of the first session of the House of Delegates in Annual Meeting,~~ and that no nomination for Councilor may be presented at any meeting unless the foregoing has been complied with or unless such compliance shall have been COMPLIANCE WITH THE FOREGOING FILING REQUIREMENT MAY BE waived or dispensed with by a vote of at least two-thirds (2/3) of the delegates present at the opening session of such meeting.

Section 5. Nomination of Officers and of Delegates and Alternate Delegates to the American Medical Association. The report of the Committee on Nominations with respect to all offices, except that of President-Elect, and with respect to all Delegates and Alternate Delegates to the American Medical Association, except for the alternate delegate elected by the Medical Student Section, shall be posted at the registration desk of the Association at the earliest time practicable and at least three hours before the final session of the House of Delegates. OR DISTRIBUTED PRIOR TO THE ELECTION. Nominations for the office of President-Elect shall MAY be made from the floor at the final session of the House of Delegates. Each nominating speech for any office shall be limited to three minutes. Not more than one speech shall be made in seconding a given nomination and such seconding speech shall be limited to one minute.

Section 6. Nominations from the Floor. Nothing in this chapter shall be construed to prevent additional nominations from the floor by delegates.

Section 7. Election of Officers and of Delegates and Alternate Delegates to the American Medical Association. IF THERE IS MORE THAN ONE NOMINEE FOR AN OFFICE, The election of officers of this Association and of delegates and alternate delegates to the American Medical Association shall be by ballot. The election of delegates to the American Medical Association shall be conducted by means of a single ballot sheet and the election of alternate delegates shall likewise be conducted by means of a separate single ballot sheet. Election of one alternate delegate to the American Medical Association by the OSMA Medical Student Section shall be in accordance with the bylaws of the Medical Student Section.

In the event there is only one position to be filled, the nominee receiving the majority of all votes cast shall be declared elected. In case no nominee receives a majority on the first ballot, the two nominees receiving the lowest number of votes shall be dropped and a new ballot taken; this procedure shall be continued until there are two nominees remaining. The nominee receiving a majority of all votes cast shall be declared elected.

In the event there is more than one position to be filled from among any number of nominees, a nominee, in order to be declared elected, must receive the votes of a majority of those voting, provided, however, that if upon any ballot the number of nominees receiving a majority vote is greater than the number of positions to be filled on such ballot, those nominees (not to exceed the number of positions to be filled on such ballot) receiving the greatest number of votes shall be declared elected. If upon any ballot some but not all of such positions are filled, a new ballot shall be taken from among all of the remaining nominees; except that the two nominees receiving the lowest number of votes on the previous ballot shall be dropped on each new ballot until there are two more nominees than positions available, after which the nominee receiving the lowest number of votes shall be dropped. On every ballot a nominee, in order to be declared elected, must receive the votes of a majority of those voting, provided, however, that if upon such new ballot the number of nominees receiving a majority vote is greater than the number of positions to be filled on such ballot, those nominees (not to exceed the number of positions to be filled on such ballot) receiving the greatest number of votes cast shall be declared elected. If upon any ballot no nominee receives the votes of a majority of those

Chapter 5, Section 5 - Eliminates the three-hour posting of candidates requirement and replaces it with a posting or distribution of the nominees prior to the election.

Chapter 5, Section 7 - Eliminates the requirement of separate ballots for delegates and alternates to the AMA. This change will permit the House to vote on candidates as it so desires. If two ballots are not necessary, the House can vote on one ballot.

voting, the two nominees receiving the lower number of votes shall be dropped and a new ballot will be taken; this procedure shall be continued until there are two more nominees than positions available, after which the nominee receiving the lowest number of votes shall be dropped; and this procedure shall be continued until all positions have been filled. No ballot shall be counted if it contains fewer or more votes than the number of positions to be filled or if the ballot purports to cast more than one vote for any nominee. (For example: if upon any ballot the number of positions to be filled is four (4), then each delegate voting must vote for (4) of the nominees for such positions.)

Section 8. Removal from Office. Any officer of this Association, or any delegate to the American Medical Association, or any alternate delegate to the American Medical Association, may be removed from office, for cause, at any time.

Proceedings for the removal from office of an officer of this Association or any delegate or alternate delegate to the American Medical Association shall be commenced by the filing with the Executive Director of this Association of a written complaint signed by not less than sixty delegates to the House of Delegates of this Association from at least thirty component societies. Such complaint shall name the person sought to be removed, shall state the cause for removal, and shall demand that a meeting of the House of Delegates be held for the purpose of conducting a hearing on the charges set forth in the complaint, and for the purpose of selecting an individual to fill the office which may be vacated by reason of the removal from office of the person sought to be removed.

Within ten (10) days after the filing of such complaint, the Executive Director shall serve upon the person named in ~~such~~ THE complaint a true and correct copy of ~~such~~ complaint IT, together with a written notice specifying the time and place of hearing the charges set forth in ~~such~~ THE complaint. The Executive Director shall also mail a copy of ~~such~~ THE complaint and notice to each delegate to the House of Delegates of this Association. Service upon the person named in ~~such~~ THE complaint of a copy of the complaint together with such written notice shall be made by delivering the same personally to ~~such~~ THE person or by sending the same by certified mail addressed to ~~such~~ THE person at his usual place of residence.

At the hearing upon such charges the person named in ~~such~~ THE complaint shall be afforded full opportunity to be heard in his/HER own defense, to be represented by legal counsel OR ANY OTHER PERSON of his/HER own choosing, to cross-examine the witnesses who testify against him/HER, and to examine witnesses and offer evidence in his/HER own behalf. The House of Delegates shall convene for the purposes of hearing the charges in such complaint, and electing a successor if need be:

(a) on any date during the Annual Meeting of the House of Delegates, provided the date of such Annual Meeting is more than thirty (30) and less than sixty (60) days subsequent to the date of the service of such written notice upon ~~such~~ THE person sought to be removed; or

(b) at a special meeting called for the purpose of hearing the charges set forth in such complaint; ~~which~~ SUCH special meeting shall be held on a date more than thirty (30) and less than sixty (60) days subsequent to the date of the service of ~~such~~ THE written notice upon such person sought to be removed.

A quorum FOR THE PURPOSES OF THIS SECTION shall consist of two-thirds (2/3) of the elected delegates.

If two-thirds (2/3) of the delegates of the House of Delegates present and voting by secret ballot vote affirmatively to remove such person from office, such person shall be declared removed from office.

A successor to an office in which a vacancy has been created as a result of the removal from office of any such officer, delegate or alternate delegate shall be elected to serve the balance of the term of such office. All nominations for ~~such~~ THE office shall be made from the floor. The election of a successor officer, delegate or alternate delegate shall be by a majority of the delegates present and voting and shall be in accordance with Section 5 of Chapter 5 of the Bylaws of this Association, and with respect to a successor delegate or alternate delegate to the American Medical Association such election shall also be in accordance with Section 5 of Chapter 4 of the Bylaws of this Association.

CHAPTER 6
DUTIES AND TERMS OF OFFICERS AND OF
THE EXECUTIVE DIRECTOR

Section 1. President. The President shall preside at all general sessions of this Association and sessions of the House of Delegates. ~~He~~ THE PRESIDENT shall appoint all committees for the selection of which other provision is not made; ~~He~~ shall deliver an annual address at a session of the House of Delegates; ~~He~~ shall be chairman of the Council and shall perform such other duties as pertain to ~~the principal administrative~~ AN officer of a corporation; ~~AND He~~ shall be an ex-officio member of all committees of this Association. ~~As THE Immediate Past President he shall be a member of Council for a period of one year immediately following his THE term of office as President. If the office of President shall become vacant, the Immediate Past President shall succeed to the Presidency and complete the unexpired term of such office; and in the event of the refusal or inability of the Immediate Past President to fill such vacancy, the President-Elect shall succeed to the Presidency and serve out the balance of such unexpired term.~~

Section 2. President-Elect. The President-Elect shall be a member of the Council and an ex-officio member of each standing committee, ~~of the Auditing and Appropriations Committee;~~ and of each ~~special or~~ other committee OR TASK FORCE appointed by the President. ~~He~~ THE PRESIDENT-ELECT shall assume the duties of the President during the temporary absence or disability of the latter. If the office of President shall ~~become~~ BE DECLARED vacant BY COUNCIL and the Immediate Past President shall refuse or be unable to fill such vacancy, the President-Elect shall serve as President during the balance of the unexpired term and thereafter during the term for which the President-Elect was elected.

Section 3. Immediate Past President. The Immediate Past President shall be a member of the Council for a period of one year immediately following ~~his~~ THE term of office as President, and during such period ~~he~~ shall be an ex-officio member of each standing committee, ~~of the Auditing and Appropriations Committee;~~ and of each ~~special or~~ other committee OR TASK FORCE appointed by the President. ~~The Immediate Past President, as well as all Past Presidents of this Association, shall have the right of the floor for discussion at all meetings of the House of Delegates. IF THE OFFICE OF PRESIDENT SHALL BE DECLARED VACANT BY COUNCIL, THE IMMEDIATE PAST PRESIDENT SHALL SUCCEED TO THE PRESIDENCY AND COMPLETE THE UNEXPIRED TERM OF SUCH OFFICE.~~

Section 4. Secretary-Treasurer. The Secretary-Treasurer shall receive all funds due this Association from every source ~~whatever, except current accounts due The Journal in the conduct of its business.~~ ~~He~~ THE SECRETARY-TREASURER shall SUPERVISE THE deposit and keep the funds of this Association in a bank or banks of deposit approved by the Council. ~~He~~ THE SECRETARY-TREASURER shall SUPERVISE THE ACCOUNTING FOR ~~keep a complete set of books concerning the receipts and expenditures of this Association, except those of The Journal.~~ ~~He~~ THE SECRETARY-TREASURER shall have the duty to make such purchases, sales, leases, acquisitions or dispositions of real and personal property as may be ordered or authorized by the Council and to execute on behalf of this Association, all documents and papers which may be required in connection with any such purchases, sales, leases, acquisitions or dispositions. ~~He shall pay money out of the treasury upon vouchers as directed by the Auditing and Appropriations Committee, rendering a monthly trial balance of his accounts to each member of Council.~~ THE SECRETARY-TREASURER SHALL SUPERVISE THE PAYMENTS OF ALL BILLS OF THE ASSOCIATION AS AUTHORIZED BY THE AUDITING AND APPROPRIATIONS COMMITTEE AND/OR THE COUNCIL. At the expense of this Association ~~he~~ THE SECRETARY-TREASURER shall give bond in such amount as shall be required by the Council.

The Secretary-Treasurer shall be a member of Council and an ~~ex-official~~ OFFICIO member of the Auditing and Appropriations Committee.

Section 5. Executive Director. The Executive Director shall be appointed by the Council. ~~He~~ THE EXECUTIVE DIRECTOR shall be THE ex-officio ~~the~~ secretary of the Association, of its Council, and of all its committees. ~~He~~ THE EXECUTIVE DIRECTOR shall be the executive agent of this Association and shall transact its business under the direction of its officers. ~~He~~ THE EXECUTIVE DIRECTOR shall

Chapter 6, Section 1 - The Past President's responsibilities are moved to Section 3 - Immediate Past President for internal consistency.

Chapter 6, Section 4 - Updates the language defining the responsibilities of the Secretary-Treasurer. The Secretary-Treasurer is responsible for supervising the financial activities of the OSMA.

Chapter 6, Section 5 - These revisions clarify the responsibilities of the Executive Director.

collect, through the secretaries of the component societies, dues for membership in this Association and dues for membership in the American Medical Association and he shall remit to the Secretary-Treasurer of this Association all collected dues for membership in this Association and shall remit to the secretary of the American Medical Association all collected dues for membership in that association.

~~He~~ THE EXECUTIVE DIRECTOR shall be the managing editor and business manager of ANY PUBLICATION OR COMMUNICATIONS PROGRAM OF THE ASSOCIATION. ~~The Journal. He shall pay over the excess of receipts over expenses, if any, of The Journal to the Secretary-Treasurer at the end of each fiscal year, or whenever ordered to do so by the Auditing and Appropriations Committee or the House of Delegates. Whenever the income of The Journal does not meet its expenses, he shall make requisition, with the approval of the Auditing and Appropriations Committee and the Council, on the Secretary-Treasurer for the necessary funds.~~ He THE EXECUTIVE DIRECTOR shall have charge of the business offices of this Association and may employ, SUPERVISE, AND DISCHARGE such aid as IS NECESSARY TO ACCOMPLISH THE PROGRAMS AUTHORIZED BY THE COUNCIL AND THE HOUSE OF DELEGATES. ~~shall be authorized by the Council.~~ He THE EXECUTIVE DIRECTOR shall be the custodian of all books and papers belonging to this Association except those of the Secretary-Treasurer.

~~He~~ THE EXECUTIVE DIRECTOR shall provide for the registration of the members at the Annual Meeting and shall provide for reporting the proceedings of the Annual Meeting. ~~He~~ THE EXECUTIVE DIRECTOR shall conduct the official correspondence, notifying members of meetings, officers of their election, committees of their appointments and duties, and ~~he~~ THE EXECUTIVE DIRECTOR shall perform such other duties as may be assigned to him by the President or the Council. At the expense of this Association ~~he~~ THE EXECUTIVE DIRECTOR shall give bond in such amount as shall be required by the Council.

Section 6. Terms of Officers. The President shall serve one year and shall be succeeded by the President-Elect. The term of office of the Secretary-Treasurer shall be for three years. The term of office of Councilors shall be for two years. Councilors of the odd-numbered districts shall be elected at annual meetings held in even-numbered years; and the Councilors of the even-numbered districts shall be elected in odd numbered years. All these officers shall serve until their successors are elected and qualified.

For the purposes of this section, the period from one Annual Meeting until the next shall be regarded as one year.

CHAPTER 7 THE COUNCIL

Section 1. Powers and Duties of the Council. The BOARD OF TRUSTEES (REFERRED TO HEREIN AS "THE COUNCIL") shall be the executive body of this Association. Between meetings of the House of Delegates, the Council shall have and exercise all the powers and authority conferred on the House of Delegates by the Constitution and these Bylaws. In the exercise of the interim powers thus conferred upon it, the Council shall take no action contravening any general policy which shall have been adopted by the House of Delegates and which is then in effect.

The Council shall have direction of the investment and reinvestment of the funds of this Association.

~~The Council shall determine the character and scope of the scientific proceedings of this Association and at least thirty (30) days prior to each Annual Meeting, it shall issue a program announcing the order in which papers and discussions are to be presented.~~

The Council shall ~~be the board of censors of this Association,~~ considering all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates involving the professional relations of individual physicians or groups of physicians shall be referred to the Council without

Chapter 7, Section 1 - Deletes reference to scientific proceedings. Revises the role of Council regarding discipline of members.

discussion. The Council shall have full power and authority to REFER TO A COMMITTEE OR TASK FORCE OR hear and decide all questions of discipline affecting the conduct of the members of this Association or the conduct of a component society. Its decisions in all cases, including questions regarding the right of membership in this Association, shall be final.

The Council shall provide for and superintend the issuance of ANY PUBLICATIONS OF ~~the Ohio State Medical Journal~~ ASSOCIATION. ~~referred to herein otherwise as The Journal.~~ It shall have full power and authority to appoint a medical editor or publication board, or both, and make any other provisions for the publication: ~~of The Journal~~ ANY PUBLICATIONS which in its judgment are feasible including full discretionary power: (1) to promulgate rules and regulations governing the ANY publicationS: ~~of The Journal~~; (2) to enumerate and define the powers and duties of the medical editor or publication board, or both; and (3) to fix the terms and conditions of their appointment.

The Council shall have full power and authority to employ an Executive Director, who need not be a physician or member of this Association; ~~and to employ such other employees as the Council may deem necessary or advisable.~~ THE EXECUTIVE DIRECTOR MAY EMPLOY SUCH OTHER EMPLOYEES AS ARE DEEMED NECESSARY OR ADVISABLE.

The Council shall provide such offices for the headquarters of this Association as may be required properly to conduct its business.

Section 2. Council Meetings. The Council shall hold meetings during the Annual Meeting of this Association and at such other times as ~~necessity may require~~ NECESSARY, subject to the call of the President or on the petition of three Councilors filed with the Executive Director.

Section 3. Publication of Proceedings. The Council shall cause to be published in ~~The Journal of this Association~~ a summary of its meetings and actions.

Section 4. Individual Duties of Councilors. Each Councilor ~~shall be the organizer, peacemaker and censor for his district.~~ He shall visit each county in ~~his~~ THAT COUNCILOR'S district at least once each year for the purposes of inquiring into the condition of the profession and of each component society in ~~his~~ THAT district and of keeping in touch with the activities of each of such societies. ~~In every disciplinary matter involving a member of a component society located in the Councilor's district, the Councilor, in advance of a hearing on any charges filed against such member, shall make every effort to effect a conciliation or compromise consistent with honor and the principles of medical ethics.~~

The duties of the ~~non-voting~~ Councilor from the Hospital Medical Staff Section shall be set forth in the bylaws of said section. The duties of the ~~non-voting~~ Councilor from the Medical Student Section shall be set forth in the Bylaws of said section. The duties of the Councilor from the Resident Physician's Section shall be set forth in the Bylaws of said section which shall be approved by the Council.

Section 5. Auditing and Appropriations Committee. An Auditing and Appropriations Committee consisting of three members of the Council shall be appointed by the President, with the consent of the Council, to serve for one year. This Committee shall prescribe the method of accounting and shall audit any and all accounts of this Association. It shall prepare and present annually to the Council a budget providing for the necessary expenses of this Association. The budget, after approval by the Council, shall be published and distributed to the delegates and alternate delegates at least 90 days prior to the Annual Meeting. Any surplus or balance of funds for a given year shall revert to the general fund. The President, the President-Elect, the Immediate Past President and the Secretary-Treasurer shall be ex-officio members of such Committee with full voting rights.

Section 6. Salaries and Expenses of Officers and Employees THE BUDGET. ~~The salaries-~~ STIPENDS of officers and ~~employees~~ THE BUDGET of this Association shall be fixed by the Council. The Auditing and Appropriations Committee may allow the payment of necessary traveling and other expenses incurred by officers and

Chapter 7, Section 1 - Restates Council's authority regarding OSMA publications without limiting it to Ohio Medicine, (The Journal).

Restates Council's authority to hire Executive Director and Executive Director's authority to hire/fire all other staff.

Chapter 7, Section 4 - Revises role of Councilor in disciplinary matters pursuant to OSMA House of Delegates direction in 1990.

Councilors in the discharge of their duties to this Association.

Section 7. Vacancies. Except as otherwise provided by Chapter 6 hereof, the Council shall fill by appointment any vacancy in office occurring in the interval between the Annual Meetings of the House of Delegates. Any such appointee shall serve until the next Annual Meeting of the House of Delegates at which time the office shall be filled in the manner provided for in the Constitution and in these Bylaws.

CHAPTER 8 DELEGATES AND ALTERNATE DELEGATES TO THE ~~AMA~~ AMERICAN MEDICAL ASSOCIATION

Section 1. Organization. As soon as practicable after their election and installation, the Delegates and Alternate Delegates to the American Medical Association shall nominate from their membership candidates for the ~~chairmanship~~ CHAIR and ~~vice-chairmanship~~ VICE-CHAIR of the delegation and the Council of this Association shall elect one of such nominees as ~~Chairman~~ CHAIR and one as ~~Vice-Chairman~~ VICE-CHAIR. The President of this Association will be ex-officio ~~Co-Chairman~~ CO-CHAIR of the delegation.

Section 2. Duties of the ~~Chairman~~ CHAIR. ~~He~~ THE CHAIR shall act as ~~Co-Chairman~~ CO-CHAIR with the President of this Association of meetings of the delegation. ~~He~~ THE CHAIR shall appoint such committees as may be necessary to assist the work of the delegation. ~~He~~ THE CHAIR shall report periodically for the delegation to the Council of this Association.

Section 3. Duties of the ~~Vice-Chairman~~ VICE-CHAIR. ~~He~~ THE VICE-CHAIR shall perform the duties of the ~~Chairman~~ CHAIR when the ~~Chairman~~ CHAIR is absent or otherwise unable to function.

SECTION 4. DUTIES OF AMERICAN MEDICAL ASSOCIATION DELEGATION MEMBERS. MEMBERS OF THE OHIO DELEGATION TO THE AMERICAN MEDICAL ASSOCIATION ARE EXPECTED TO ATTEND ALL SESSIONS OF THE AMA HOUSE OF DELEGATES AND ALL OHIO AMA DELEGATION FUNCTIONS. MEMBERS OF THE OHIO DELEGATION TO THE AMA MUST PREPARE FOR EACH AMA HOUSE OF DELEGATES MEETING BY REVIEWING MATERIALS SENT TO THEM AND PARTICIPATE IN THE DELIBERATIONS OF VARIOUS COMMITTEES TO WHICH THEY MAY BE ASSIGNED. MEMBERS OF THE OHIO DELEGATION TO THE AMA SHALL PARTICIPATE IN MEMBERSHIP PROMOTION ACTIVITIES IN THEIR LOCAL SOCIETIES AND DISTRICTS FOR BOTH THE OSMA AND THE AMA.

Section 45. Terms of Office. The ~~Chairman~~ CHAIR and ~~Vice-Chairman~~ VICE-CHAIR shall serve for a period of one year or until their successors are duly elected and qualified.

Section 56. Terms of Office for Medical Student Section Alternate Delegate. The Alternate Delegate elected by the Medical Student Section shall serve for a period of one year from the time of election. This Alternate Delegate shall be eligible for reelection so long as medical student status is maintained.

CHAPTER 9 COMMITTEES

Section 1. ~~Titles of~~ Committees. The standing Committees of this Association shall be THE COMMITTEE ON AUDITING AND APPROPRIATIONS AND THE COMMITTEE ON JUDICIAL AND PROFESSIONAL RELATIONS. ALL OTHER COMMITTEES AND TASK FORCES OF THIS ASSOCIATION SHALL BE ~~the~~ following:

1. ~~Committee on Communications;~~ 2. ~~Committee on Accreditation;~~ 3. ~~Committee on Education;~~ 4. ~~Committee on Judicial and Professional Relations;~~ 5. ~~Committee on Membership;~~ and 6. ~~Committee on Art and Culture.~~

Establishes in the Bylaws the duties of members elected to the AMA House of Delegates. These activities were approved by the OSMA/AMA delegates and alternates in 1990.

Chapter 9, Section 1 and Section 2 - Reduces the standing committees to A&A and JP&R, then restates authority of President to appoint all committee members and Task Forces.

~~Other committees of this Association shall be those designated in Section 4 and 7 of Chapter 4; Section 1 of Chapter 5 and Section 5 of Chapter 7, and such special committees as may be appointed by the pPresident.~~

Section 2. Appointment. The President with approval of Council shall appoint the ~~chairman~~ CHAIR and members of each ~~standing and special committee~~:AND TASK FORCE. Each ~~committee chairman~~ shall serve a one year term, and may serve a maximum of three consecutive one year appointments. A committee chairman who has served three one year appointments is eligible for reappointment as chairman after one year. The limitations on years of service as chairman shall not affect the member's right to be appointed to serve on any committee.

Each committee member shall be appointed for a two year term, except for the first appointments at which time one-half of the committee shall be appointed for one year and one-half of the committee shall be appointed for two years. Each committee member is limited to three consecutive two year terms on any one committee. A member having served the maximum of three consecutive two year terms is eligible for reappointment to such committee after one year. A member may serve on more than one committee simultaneously. If a vacancy occurs in any committee, the President with approval of Council, may fill the vacancy for the remainder of the term.

Section 3. Duties and Responsibilities of Committees:AND TASK FORCES. Each ~~standing and special~~ committee AND TASK FORCE shall consider all items referred thereto by the House of Delegates and the Council. The purpose(s) of each committee AND TASK FORCE shall be prescribed by the Council.

The actions of all ~~standing and special~~ committees AND TASK FORCES shall be subject to the approval of the Council.

CHAPTER 10 COMPONENT SOCIETIES

Section 1. Organization of Societies. Upon application to the House of Delegates, all component societies hereafter organized in this state, which have adopted principles of organization in conformity with the Constitution and Bylaws of this Association, shall receive charters from this Association; provided, however, that their constitutions and bylaws or, ~~in the case of incorporated societies;~~ their articles of incorporation, codes of regulations, codes of bylaws or other fundamental bodies of rules of society government, shall have been submitted to the Council and received its approval. All such charters shall be signed by the President and the Secretary-Treasurer.

Section 2. Suspension or Revocation of Charters of Societies. The House of Delegates shall have authority and power to suspend or revoke a charter heretofore or hereafter issued to any component society whose actions are in conflict with the Constitution or Bylaws of this Association.

Section 3. Title of a Component Society. The name and title of each component society shall read exactly as found in its charter. No change in such name shall be made without the approval of the Council of this Association.

Section 4. Custody of Charter. The charter of each component society, as issued by this Association, shall be preserved and shall be kept in the custody of the secretary of such component society at all times.

Section 5. Constitutions of Component Societies. Each unincorporated component society shall have a constitution and bylaws. Each incorporated component society shall have, in addition to articles of incorporation as required by law, a constitution, a code of regulations, a code of bylaws, or other fundamental body of rules for its government similar in content and form to the bylaws of unincorporated component societies. All such constitutions, bylaws, articles of incorporation, codes of regulations and other fundamental bodies of rules AND ALL OTHER RULES AND REGULATIONS ADOPTED BY A COMPONENT SOCIETY shall be in conformity to NOT BE IN CONFLICT WITH the Constitution and Bylaws of this Association, and a copy thereof shall be transmitted to the headquarters of this Association for approval and

This is to clarify that component societies may adopt provisions that are not addressed in the OSMA Constitution and Bylaws.

recording. The bylaws of each unincorporated component society, and the code of regulations, code of bylaws, or other fundamental body of rules of each incorporated society shall set forth specifically the duties of the several officers and of its executive body (council or trustees).

Section 6. RULES, REGULATIONS AND Changes In Constitution and Bylaws of Component Societies. Whenever a component society ~~shall have made~~ **MAKES** a change or amendment in its constitution, bylaws, articles of incorporation, code of regulations, or other fundamental body of rules for its government, **OR ADOPTS ANY RULES OR REGULATIONS, WHICH AFFECT THE RELATIONSHIP OF THE COMPONENT SOCIETY WITH THE ASSOCIATION OR THE RIGHTS OF ANY ASSOCIATION MEMBER,** such change, ~~or amendment,~~ **RULE OR REGULATION** shall be submitted to the Council of this Association for written approval, and ~~such change or amendment~~ shall not become effective until such approval ~~shall have~~ **HAS** been given.

Section 7. Functions and Duties of Component Societies. Each component society shall have general direction of the business and affairs of the profession in the county, and it shall exert its influence to promote the science and art of medicine, the moral condition of the membership, and the betterment of public health.

Section 8. Date Membership Dues are Payable. The membership dues in all component societies shall be due and payable on or before December 1 preceding the calendar year for which such dues are assessed.

Section 9. Official Records of Component Societies. The official copy of the constitution and bylaws of each unincorporated component society, and the official copy of the articles of incorporation, code of regulations, code of bylaws or other fundamental body of rules of each incorporated component society, shall be kept by such component society in a special book provided for that purpose. ~~In such special book shall be entered~~ All amendments which have been approved by the Council of this Association **SHALL BE ENTERED IN A SPECIAL BOOK.** ~~Such book shall contain the name and address of each component society member who is entitled to membership in this Association; and there shall be recorded in it the date of each member's selection, the date of his decease and the date of any resignation or order of suspension or expulsion from the society. It shall be the duty of the society's secretary to preserve this book and hold it available when required for reference.~~

Section 10. Certification of Delegates of Component Societies. Each component society at its regular annual meeting shall elect delegates to represent it in the House of Delegates of this Association in accordance with these Bylaws, unless other definite procedure for the selection of delegates is provided in its constitution and bylaws, or in its articles of incorporation, code of regulations, code of bylaws, or other fundamental body of rules of society government. The secretary of each component society shall send a list of such delegates and alternates to the Executive Director of this Association at least ~~thirty (30)~~ **SIXTY (60)** days before the Annual Meeting of this Association. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions. In the absence of, or the disability or disqualification of a delegate, ~~his~~ **THE DELEGATE'S** duly certified alternate shall be seated in ~~his~~ **THE DELEGATE'S** place.

Section 11. Combined Component Societies. The House of Delegates shall have authority to organize the physicians of two or more counties, or parts thereof, into a multi-county society to be designated by hyphenating the names of such counties so as to distinguish them from a district or single county society. Such multi-county societies, when organized and chartered, shall be entitled to all the privileges and representatives provided herein for component societies.

CHAPTER 11 MEMBERSHIP IN COMPONENT SOCIETIES

Section 1. Qualifications for Membership In a Component Society. To be eligible for ~~ANY CLASS OF VOTING active membership, associate membership or in-training membership~~ in a component society or other probationary or provisional type of membership of limited duration, a person must possess all of the following qualifications:

(a) ~~He~~ A PERSON must meet all those requirements for membership in this Association which are enumerated in Section 3 of Chapter 1, hereof, and at the time of making application to the component society shall tender the appropriate Ohio State Medical Association dues and assessments for the current year;

(b) ~~He~~ A PERSON must be a bona fide resident of, or must conduct the major portion of his/HER practice in, the county in which such component society is located.

~~Provided, however, that where it is more convenient for a member of a component society to attend the meetings of another component society located in a county adjoining that in which he holds such membership, such member, upon application to, and approval by, both the society in which he holds such membership and the society in such adjoining county, shall be entitled to a transfer of his membership to the latter society; and, provided further, that. No~~ A person possessing an active membership, associate membership, or in-training membership, or probationary, or provisional type of membership of limited duration, in one component society may acquire or possess at the same time an active membership, or an associate, or probationary or provisional type of membership of limited duration, in another component society, BUT MAY BE COUNTED FOR PURPOSES OF REPRESENTATION IN THE OSMA HOUSE IN ONLY ONE COMPONENT SOCIETY.

As used in this Section 1, "active membership" in a component society means any type of membership having voting and office-holding rights and privileges.

Subject to the provisions of the foregoing paragraphs of this Section 1, each component society shall be the sole judge of the qualifications necessary for any and all classes of membership in such society.

Section 2. Roster of Members. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college AND MEDICAL OR OSTEOPATHIC SCHOOL and dateS of graduation, date of license to practice in this state, and such other information as may be deemed necessary by Council.

Section 3. Change of Residence. When a member in good standing in a component society moves to another county in this state, ~~he~~ THE MEMBER shall be given upon request a written certificate of those facts by the secretary of ~~his~~ THE society, without cost, for transmittal to the secretary of the component society in the county to which ~~he~~ THE MEMBER moves. Pending ~~his~~ acceptance or rejection by the society in the county to which ~~he~~ THE MEMBER moves, such member shall be considered to be in good standing in the component society from which ~~he~~ THE MEMBER was certified and in this Association to the end of the period for which ~~his~~ THE MEMBER'S dues have been paid.

Section 4. Disciplinary Procedure. Disciplinary action may be taken by a component society against a member thereof only upon written charges signed by a ~~member or~~ members of such society and filed with the society's secretary. IF AFTER REVIEWING THE COMPLAINT, THE COMPONENT SOCIETY DETERMINES THAT DISCIPLINARY ACTION IS ADVISABLE, THE SECRETARY OF THE SOCIETY SHALL PROMPTLY GIVE NOTICE OF THE PROPOSED ACTION TO THE MEMBER, INCLUDING THE RIGHT OF THE MEMBER TO REQUEST A HEARING WITHIN THIRTY (30) DAYS OF THE DATE OF NOTICE, AND A SUMMARY OF THE RIGHTS AND PROCEDURES TO BE FOLLOWED IN A HEARING. A COPY OF THE NOTICE SHALL ALSO BE FURNISHED TO THE DISTRICT COUNCILOR. ~~As soon as possible, and in any event not later than ten (10) days after such filing, the secretary shall serve upon the accused member a true copy of such charges and shall also furnish to the Councilor for the district a copy thereof. Within thirty (30) days thereafter, the society shall fix a time and place for a hearing on said charges and the secretary shall serve prompt written notice of such time and place upon the accused member and shall also furnish to the Councilor for the district a copy of such notice. Such hearing shall be held as soon as practicable but in no event sooner than twenty (20) UPON RECEIPT OF A REQUEST FOR HEARING, A HEARING SHALL BE SCHEDULED TO COMMENCE NOT LESS THAN THIRTY (30) days, or later than sixty (60) NINETY (90) days, after the date of service of such notice upon the accused member. RECEIPT OF THE REQUEST FOR HEARING. Service upon the~~

Chapter 11, Section 1 - The Council revised this section to permit individuals to be Active Members in multiple county societies. However, the revision does not permit these physicians to be counted in more than one (1) component society as an Active Member for OSMA House of Delegates representation.

Chapter 11, Section 4 - As currently written, a component society must proceed through the hearing process upon receipt of written charges. The proposed changes give the component societies the ability to avoid this process if it determines, based upon the complaint, that disciplinary action is not necessary. In addition, the member is given the option of requesting a hearing or waiving that right. These changes are intended to simplify the process in the case of frivolous complaints or when the member does not contest the charges.

accused of a copy of such charges or of such written notice, or both, may be made by delivering the same personally to the accused, or by sending the same by registered mail and also by regular mail addressed to the accused at ~~his~~ THE ACCUSED'S usual place of residence.

At the hearing upon such charges the accused shall be afforded full opportunity to be heard in his/HER own defense, to be represented by legal counsel OR ANY OTHER PERSON of his/HER own choosing. THE ACCUSED, LEGAL COUNSEL OR OTHER REPRESENTATIVE OF THE ACCUSED SHALL HAVE THE RIGHT to cross-examine the witnesses who testify against ~~him~~ THE ACCUSED, and to examine witnesses and offer evidence in his/HER own behalf. The hearing shall be held and conducted in such a manner as to ascertain all the facts fairly to the accused and the society without requiring compliance with those formal or technical rules and requirements which ordinarily pertain to judicial proceedings. Failure of the accused to appear or be represented at the hearing may be considered prima facie evidence of the truth of the charges.

A record shall be made of such hearing, and at the request of either the accused member or the component society, the society's secretary shall cause a transcript to be made of the proceedings, evidence and findings in connection with such hearing ~~without charge to the accused member.~~ UPON PAYMENT OF ANY REASONABLE CHARGES ASSOCIATED WITH THE PREPARATION THEREOF. If the findings shall include, or be followed by, an order or decree of the component society suspending or expelling the accused member from the society, the execution or enforcement of such order or decree shall be stayed until ~~the expiration of~~ 30 DAYS FOLLOWING the time allowed by Section 5 hereof for the perfecting of an appeal to the OSMA, and thereafter shall be stayed during the pendency of any appeal that may have been timely ~~filed~~ REQUESTED and ~~perfected~~ ACCEPTED. Prompt written notice of the findings and order or decree shall be served by the secretary upon the accused member together with a copy of such findings and order or decree.

Section 5. TRANSFER OF DISCIPLINARY PROCEDURE. IF AFTER INVESTIGATION A COMPONENT SOCIETY DETERMINES THAT IT IS UNABLE TO CONDUCT A DISCIPLINARY ACTION IN A FAIR AND UNBIASED MANNER, THE COMPONENT SOCIETY MAY REQUEST THE ASSISTANCE OF OSMA COUNCIL IN THE CONDUCT OF THE PROPOSED DISCIPLINARY PROCEDURES. SUCH REQUEST SHALL BE MADE IN A WRITING SIGNED BY NO FEWER THAN THREE MEMBERS OF THE COMPONENT SOCIETY FAMILIAR WITH THE FINDINGS OF THE INVESTIGATION AND DELIVERED TO THE EXECUTIVE DIRECTOR OF THE ASSOCIATION.

UPON NOTIFICATION OF A REQUEST FOR ASSISTANCE, COUNCIL SHALL APPOINT A COUNCILOR FROM A DISTRICT THAT DOES NOT INCLUDE THE COMPONENT SOCIETY TO SERVE AS THE SUPERVISING COUNCILOR FOR THE DISCIPLINARY PROCEDURE. THE SUPERVISING COUNCILOR SHALL CONSULT WITH THE COMPONENT SOCIETY IN ORDER TO DETERMINE THE NATURE AND SCOPE OF ASSISTANCE THE ASSOCIATION SHOULD PROVIDE THE COMPONENT SOCIETY TO CONDUCT A FAIR AND UNBIASED DISCIPLINARY PROCEDURE.

THE SUPERVISORY COUNCILOR SHALL BE EMPOWERED TO PROVIDE ALL ASSISTANCE NECESSARY TO THE COMPONENT SOCIETY TO ASSURE THE MEMBER A FAIR AND IMPARTIAL DISCIPLINARY PROCEDURE. SUCH ASSISTANCE MAY INCLUDE, BUT SHALL NOT BE LIMITED TO, THE APPOINTMENT OF AN ASSOCIATION MEMBER, OR MEMBERS, WHO ARE NOT MEMBERS OF THE COMPONENT SOCIETY, AS A HEARING OFFICER OR AS AN AD HOC HEARING PANEL; OR THE DESIGNATION OF ASSOCIATION MEMBERS TO SERVE AS EXPERTS.

ANY PROCEDURE CONDUCTED PURSUANT TO THIS SECTION SHALL BE CONDUCTED IN ACCORDANCE WITH CHAPTER 11, SECTION 4 OF THESE BYLAWS AND UNDER THE ORIGINATING COMPONENT SOCIETY'S BY-

Chapter 11, Section 5 - This addition, proposed by the Task Force and approved by Council, provides procedures for conducting a disciplinary action when the component society determines it cannot provide a fair and unbiased proceeding. Furthermore, it preserves Council as an appellate body. To a degree, this proposed procedure may conflict with Chapter 1, Section 6 wherein any three Association members can force the Council to investigate their complaint. Specifically, this new proposed addition to Chapter 1, Section 6 would allow only three members of the component society, familiar with the component society investigation, to petition the Council for assistance after stating their belief that no fair and unbiased proceedings were possible. The Executive Director would bring the petition to the attention of Council, who would appoint a Councilor to assist the component society in its proceedings. The magnitude of the assistance would depend upon the particular circumstances. Proceedings would be in compliance with Chapter 11, Section 4. Any required actions would be implemented by the component society as if the proceedings had been undertaken by the component society. The component society and OSMA would share the costs.

LAWS.

THE COST OF ANY PROCEEDING REFERRED TO COUNCIL UNDER THIS PROCEDURE SHALL BE SHARED BY THE COMPONENT SOCIETY REQUESTING THE ASSISTANCE AND THIS ASSOCIATION.

ANY FINDINGS AND ACTIONS WHICH RESULT FROM THE DISCIPLINARY PROCEEDING CONDUCTED WITH THE ASSISTANCE OF THE SUPERVISING COUNCILOR SHALL BE ENFORCED BY THE COMPONENT SOCIETY AS IF THE FINDINGS OR ACTIONS WERE THE RESULT OF A DISCIPLINARY PROCEEDING CONDUCTED BY THE COMPONENT SOCIETY WITHOUT THE ASSISTANCE OF THE SUPERVISING COUNCILOR.

ANY DISCIPLINARY PROCEDURE CONDUCTED WITH THE ASSISTANCE OF THE SUPERVISING COUNCILOR SHALL BE APPEALABLE TO COUNCIL PURSUANT TO PROVISIONS OF CHAPTER 11, SECTION 6 OF THESE BY-LAWS. IN ANY APPEAL OF THE DISCIPLINARY PROCEEDINGS CONDUCTED PURSUANT TO THIS SECTION, THE SUPERVISING COUNCILOR SHALL NOT PARTICIPATE.

Section 6. Appeals. Any member who has been censured by his/HER component society, or who has been suspended or expelled from membership therein, shall have the right to REQUEST AN appeal to the Council of this Association from the order of censure, suspension or expulsion; ~~and the Council shall have~~ MAY, IN ITS OWN DISCRETION, EXERCISE ITS jurisdiction to hear and determine such appeal, and to affirm, modify or reverse the order of the component society: OR TO REMAND THE MATTER TO THE COMPONENT SOCIETY FOR FURTHER CONSIDERATION. Any such appeal shall be on questions of law and procedure only, and not on questions of fact. ~~Such~~ THE REQUEST FOR appeal must be filed with the Council within ~~twenty (20)~~ 60 days after the date of the service upon the accused member of the component society's order from which the appeal is ~~taken~~; SOUGHT. With such REQUEST FOR appeal the appellant shall file proof that a copy of ~~such~~ THE REQUEST FOR appeal has been mailed to, or otherwise served upon, the president or secretary of the component society from whose order the appeal is ~~taken~~ SOUGHT.

WITHIN 45 DAYS AFTER THE RECEIPT OF A REQUEST FOR APPEAL, COUNCIL SHALL DETERMINE WHETHER OR NOT IT WILL EXERCISE ITS JURISDICTION TO HEAR THE APPEAL, AND NOTIFY THE MEMBER AND THE COMPONENT SOCIETY OF THAT DETERMINATION.

~~As soon as practicable, and~~ IF COUNCIL CHOOSES TO HEAR THE APPEAL within ~~forty (40)~~ SIXTY (60) days after the filing of such appeal, or within such additional time as may be allowed by the Council, the component society shall file with the Council a record of the society's disciplinary proceedings against the appellant, including the original papers, documents, resolutions and minutes, or copies thereof, relating ~~thereto~~ TO THE ACTION, and including a transcript of the proceedings, evidence and findings in connection with its hearing on the charges against the appellant. With such record there shall be filed a certificate signed by the president or secretary of such society certifying that such record constitutes a complete, true and correct record of all the disciplinary proceedings before such society, and further certifying that a true and correct copy of such record, and written notice of the filing of such record with the Council, have been mailed to, or otherwise served upon, the appellant. If the component society ~~shall~~ failS or refuseS to file such record within the said ~~forty (40)~~ SIXTY (60) days or within such additional time as may be allowed by the Council, the Council may enter an order sustaining such appeal and reversing the order or decree of the component society.

Following the filing of the record by the society the Council shall fix the time for the filing of briefs by the ~~accused~~ APPELLANT and the society and shall set a date for the hearing of the appeal before the Council, and the Executive Director shall give prompt notice thereof to each party and to each party's legal counsel.

The appeal shall be heard, considered and determined by the Council solely upon the

Chapter 11, Section 6 - The proposed changes to this section grant OSMA Council greater latitude in handling appeals from decisions of a component society. Council would have the discretion to decline to hear the appeal. It should be noted that under the draft Model County Bylaws that were circulated in 1990 there is an internal appeal process at the component society level. Accordingly, an appeal to OSMA Council actually would be a second level appeal, and, therefore, could be made discretionary.

In addition, the proposed changes include the ability of Council, after hearing the appeal to remand the matter to the component society for further consideration. This option can be used if the component society made technical errors in its process or did not consider some relevant evidence. These changes also clarify that except in extraordinary circumstances, peer review is the responsibility of the component society.

record filed by the society with the Council and upon the briefs and oral arguments of the parties or their legal counsel; ~~and t~~The decision of the Council shall be final and binding on both the accused member and the society.

~~**Section 6. Effect of Failure of a Component Society to take Requested Disciplinary Action.** In the event that a component society shall fail or refuse to take prompt disciplinary action against one of its members after being requested in writing by the Council of this Association to do so, the Council of this Association may cause such disciplinary action to be instituted and prosecuted; and in any such disciplinary action so instituted the procedure prescribed by Section 6 of Chapter 1 of these Bylaws shall govern; and at the conclusion of the hearing by the Council it may enter such order of (a) dismissal of the charges, or (b) censure of the accused member, or (c) suspension from the society, or (d) expulsion from the society as the evidence adduced at such hearing shall warrant. The accused member may appeal the decision of the Council on questions of law and procedure, but not of fact, to the Judicial Council of the AMA by filing a notice of appeal with the Judicial Council within thirty days of the decision of Council, such appeal to be governed by the rules and regulations of the Judicial Council. The decision of Council shall be final pending an appeal to the Judicial Council.~~

Section 7. Limitation of Liability. No member or employee serving on a utilization committee, a peer review or professional standards review committee, which includes participation in the context of this disciplinary Chapter, of the Association shall be deemed liable in damages to any person for any action taken or recommendation made within the scope of the functions of said committee, if such committee member or employee acts without malice and in the reasonable belief that such action or recommendation is warranted by the facts known to ~~him~~ SUCH PERSON after reasonable effort to obtain the facts of the matter as to which such action is taken or recommendation is made. NO PERSON AGAINST WHOM DISCIPLINARY ACTION IS INSTITUTED PURSUANT TO THE DISCIPLINARY CHAPTER OF THESE BYLAWS SHALL HAVE ANY CLAIM OR CAUSE OF ACTION AGAINST THIS ASSOCIATION, OR AGAINST ANY OFFICER, COUNCILOR, MEMBER, AGENT OR EMPLOYEE OF THIS ASSOCIATION, BY REASON OF THE INSTITUTION, PROSECUTION, OR DISPOSITION OF SUCH CHARGES OR THE HEARING OR CONSIDERATION THEREOF.

Section 8. Effect of Expiration, Revocation or Termination of a Certificate. Membership in a component society of a member of such society whose certificate to practice medicine and surgery, or osteopathic medicine and surgery, has expired, has been revoked or has been otherwise terminated, shall be cancelled automatically as of the effective date of such expiration, revocation, or termination. The provisions of this Section 8 shall not apply to members who have retired from active practice.

Section 9. Effect of Failure to Maintain Membership In the Ohio State Medical Association. Membership in a component society of a member of such society who has failed to acquire and maintain membership in this Association shall terminate automatically.

CHAPTER 12 ETHICAL PRINCIPLES

The ethical principles governing the members of the American Medical Association shall govern members of this Association.

Chapter 11, Section 6 (former) - Chapter 1, Section 6 of the Bylaws permits a complaint to be filed directly with the OSMA. That provision, along with the proposed change allowing the OSMA to direct the component society to hear such a complaint, renders this section unnecessary and redundant. Accordingly, the proposed draft deletes this section. This Chapter is proposed in order to give the OSMA authority to indemnify Councillors, Officers, committee members and agents of This chapter is proposed to the give the OSMA authority to indemnify Councilors, Officers, committee members and agents of the OSMA in the event of legal action based upon the performance of the person's OSMA duties. The language used in this section tracks the language of R.C. 1702.12 which provides the statutory authority for these provisions.

Chapter 11, Section 7 - As with the current version of the section, the proposed section tracks the language of the peer review immunity statute. R.C. 2305.25. However, the term "agent" has been inserted to clarify that any consultant or outside hearing examiner, who is not a member of one of the peer review committees or not a member of the OSMA but is needed in the disciplinary process, is also covered by the immunity provided by this section.

The additional language proposed to be inserted at the end of this section serves the purpose of strengthening the protection provided by this section. This language prohibits legal actions against the OSMA or any committee or participant in the disciplinary process which is based solely on disciplinary action having been taken.

CHAPTER 13 RULES OF PROCEDURE

The deliberations of this Association shall be conducted in accordance with parliamentary usage as prescribed in the current edition of Sturgis' Standard Code of Parliamentary Procedure, by Alice Sturgis.

CHAPTER 14 REFERENDUM

Within sixty (60) days after a general referendum has been ordered either by the (1) House of Delegates, or (2) upon the petition of the presidents of at least twenty-three (23) component societies as prescribed in Article X of the Constitution, the Executive Director shall prepare and have printed and mailed by first-class mail to each Active Member of this Association an official circular setting forth the following:

- (a) A resume of the provisions in this Constitution and Bylaws applying to a general referendum;
- (b) An announcement by the President as to the time set ~~by him~~ for closing the polls which shall be not less than fifteen (15) days or more than thirty (30) days after the mailing of circulars and ballots;
- (c) The resolution, motion or action submitted to referendum;
- (d) A statement of not more than 200 words prepared by the proposer or proposers of the resolution, motion or action giving arguments in its favor;
- (e) A statement of not more than 200 words giving arguments in opposition prepared by one or more members appointed by the President from among those opposed to the resolution, motion or action.

Enclosed with the circular shall be an official reply envelope and a ballot labeled with the official seal of this Association. On the ballot the resolution, motion or action shall be printed and below it shall be spaces for the indication of "yes" or "no" by making a cross mark. The reply envelope shall be addressed to a special committee of three tellers appointed by the President and it shall carry return first-class postage or the equivalent thereof under the postal regulations.

To be counted by the tellers a ballot shall meet the following requirements:

- (a) Either "yes" or "no" must be clearly indicated with a cross mark;
- (b) The ballot must be received by the committee of tellers in the sealed official reply envelope by first-class postage on or before the day set for closing the polls; and
- (c) The ballot must be an official ballot mailed to each Active Member, duly labeled with the seal of this Association.

Within ten days following the time set for closing the polls, the tellers shall meet at the headquarters office of this Association to open the envelopes containing the ballots and poll the votes in the presence of each other, keeping in mind that the referendum is not valid unless participated in by not less than one-half of the Active Members of this Association.

The results of the referendum shall be transmitted in writing by the tellers to the President immediately after the count has been completed. The President shall announce such results to the members of the Council and publication thereof shall be made. ~~in The Journal of this Association.~~ TO THE ACTIVE MEMBERS.

Except as otherwise provided in Article X of the Constitution of this Association, a resolution, motion or action receiving a majority of the votes cast in a valid referendum, shall be declared adopted, carried or ratified, as the case may be, and the same shall become effective fifteen (15) days after the results of the referendum ~~shall~~ have been

Chapter 14 - Limits the mandatory publication of results to the Active Members.

CHAPTER 15 INDEMNIFICATION

NOTE: THIS FOLLOWING SECTION PROVIDES INDEMNITY TO COUNCIL MEMBERS, OFFICERS, COMMITTEE MEMBERS, EMPLOYEES OR OTHER AGENTS USING THE STATUTORY LANGUAGE PRESCRIBED BY CHAPTER 1702 OF THE OHIO REVISED CODE.

SECTION 1. INDEMNIFICATION. IN THE EVENT THAT ANY PERSON WHO WAS OR IS A PARTY OR IS THREATENED TO BE MADE A PARTY TO ANY THREATENED, PENDING OR COMPLETED ACTION, SUIT OR PROCEEDING, WHETHER CIVIL, CRIMINAL, ADMINISTRATIVE OR INVESTIGATIVE, SEEKS INDEMNIFICATION FROM THE ASSOCIATION AGAINST EXPENSES (INCLUDING ATTORNEY FEES), AND IN THE CASE OF ACTIONS OTHER THAN THOSE BY OR IN THE RIGHT OF THE ASSOCIATION, JUDGMENTS, FINES AND AMOUNTS PAID IN SETTLEMENT, INCURRED BY HIM OR HER IN CONNECTION WITH SUCH ACTION, SUIT OR PROCEEDING BY REASON OF THE FACT THAT SUCH PERSON IS OR WAS A MEMBER OF THE COUNCIL, AN OFFICER, OR A MEMBER OF ANY COMMITTEE OR COMMISSION OF THE ASSOCIATION, OR IS OR WAS SERVING AT THE REQUEST OF THE ASSOCIATION AS A TRUSTEE, DIRECTOR, OFFICER, EMPLOYEE, AGENT OR A MEMBER OF A COMMITTEE OR COMMISSION OF ANOTHER CORPORATION (DOMESTIC OR FOREIGN, NONPROFIT OR FOR PROFIT), PARTNERSHIP, JOINT VENTURE, TRUST OR OTHER ENTERPRISE, THEN, UNLESS SUCH INDEMNIFICATION IS ORDERED BY A COURT, THE ASSOCIATION SHALL DETERMINE OR CAUSE TO BE DETERMINED IN THE MANNER PROVIDED IN SECTION 1702.12(E)(4) OF THE REVISED CODE OF OHIO WHETHER OR NOT INDEMNIFICATION IS PROPER IN THE CIRCUMSTANCES BECAUSE THE PERSON CLAIMING SUCH INDEMNIFICATION HAS MET THE APPLICABLE STANDARDS OF CONDUCT SET FORTH IN DIVISIONS (E)(1) AND (E)(2) OF SECTION 1702.12 OF THE REVISED CODE OF OHIO AND, TO THE EXTENT THAT IT IS SO DETERMINED THAT SUCH INDEMNIFICATION IS PROPER, THE PERSON CLAIMING INDEMNIFICATION SHALL BE INDEMNIFIED.

SECTION 2. ADVANCEMENT OF EXPENSES. EXPENSES, INCLUDING ATTORNEY'S FEES, INCURRED IN DEFENDING ANY ACTION, SUIT, OR PROCEEDING REFERRED TO IN SECTION 1 OF THIS ARTICLE MAY BE PAID BY THE ASSOCIATION IN ADVANCE OF THE FINAL DISPOSITION OF SUCH ACTION, SUIT, OR PROCEEDING AS AUTHORIZED BY THE COUNCIL IN THE SPECIFIC CASE UPON RECEIPT OF AN UNDERTAKING BY OR ON BEHALF OF THE PERSON REIMBURSED TO REPAY SUCH AMOUNT UNLESS IT SHALL ULTIMATELY BE DETERMINED THAT HE OR SHE IS ENTITLED TO BE INDEMNIFIED BY THE ASSOCIATION AS AUTHORIZED IN THIS ARTICLE.

SECTION 3. NON-EXCLUSIVITY OF THIS ARTICLE. THE INDEMNIFICATION PROVIDED BY SECTION 1 OF THIS ARTICLE SHALL NOT BE DEEMED EXCLUSIVE OF ANY OTHER RIGHTS TO WHICH THOSE SEEKING INDEMNIFICATION MAY BE ENTITLED UNDER THE LAW OR ANY AGREEMENT, VOTE OF DISINTERESTED MEMBERS OF THE COUNCIL OR OTHERWISE, BOTH AS TO ACTION IN HIS OR HER OFFICIAL CAPACITY AND AS TO ACTION IN ANOTHER CAPACITY WHILE HOLDING SUCH OFFICE, AND SHALL CONTINUE AS TO A PERSON WHO HAS CEASED TO HOLD SUCH OFFICE AND SHALL INURE TO THE BENEFIT OF THE HEIRS, EXECUTORS, AND ADMINISTRATORS OF SUCH A PERSON.

SECTION 4. INSURANCE. THE ASSOCIATION, TO THE EXTENT PERMITTED BY CHAPTER 1702 OF THE OHIO REVISED CODE, MAY PURCHASE AND MAINTAIN INSURANCE ON BEHALF OF ANY PERSON DESCRIBED IN THIS ARTICLE.

Chapter 15 - This chapter is proposed in order to give the OSMA authority to indemnify Councilors, Officers, committee members and agents of the OSMA in the event of legal action based upon the performance of the person's OSMA duties. The language used in this section tracks the language of R.C. 1702.12, which proposes the statutory authority for these provisions.

CHAPTER 156 AMENDMENTS

Section 1. Method of Amending. These Bylaws may be amended at any Annual Meeting of the House of Delegates by a majority vote of the delegates present at that session, provided that the proposed amendment shall have been published **TO THE ACTIVE MEMBERS** ~~in The Journal~~ or mailed to ~~all~~ **ACTIVE** Members of the Association at least thirty (30) days prior to the Annual Meeting.

Section 2. Conformity by Component Societies. When an amendment of these Bylaws has been adopted as provided in Section 1 hereof, it shall be the duty of the Executive Director to notify the secretary of each component society within sixty (60) days after such amendment has become effective. It shall become incumbent upon each component society to make such changes in its constitution and bylaws, or, if the society be a corporation, in its articles of incorporation, code of regulations, code of bylaws, or other fundamental body of rules for the government of the corporation, as will bring about conformity to the change in the Bylaws of this Association.

Within one hundred and eighty (180) days after such notification to each component society, written notice of compliance by such component society with provision, together with copies of the changes made to effect such compliance, shall be sent by the secretary of such component society to the Council for its review and approval.

CHAPTER 167

Upon the adoption of these Bylaws, all previous Bylaws are hereby declared null, void and of no effect.

New Chapter 16 - Limited publication of proposed amendments to Active Members.

/pmf
9/24/91

Modigliani

LIFE, CAREER

SIMILAR TO VAN GOGH

By James Ravin, MD

The phenomenal prices achieved by works of art at auction in recent years can be difficult to comprehend. Values have some relationship to previous sales, as well as to supply and

demand. But for some artists, the prices have priced out all but a few extremely affluent buyers.

Consider the case of Vincent Van Gogh. As an artist, he was a monetary failure during his lifetime. He was able to sell only two works, and received little for them. The intern who cared for him at the asylum in St. Remy, France, did

not put much value in the portrait Vincent made of him. He was happier when Vincent was able to obtain an old master print for him. Van Gogh's *Portrait of Doctor Gachet* is the most



expensive painting ever sold. It achieved \$82.5 million in 1990 (not including the 10% buyer's premium). It is curious that a portrait of a physician should be the most expensive work of art ever sold at auction. Pity poor Vincent. He and his family gained nothing from the sale of this work.

The artistic career of Amedeo Modigliani (1884-1920) was similar to that of Van Gogh in several respects. Both died in their mid 30s. Modigliani had tuberculous meningitis. Although not a suicide, as was Van Gogh, Modigliani abused alcohol, hashish and other drugs. In a sense, he contributed to his own demise. Modigliani's widow, nine months pregnant, committed suicide by jumping from the fifth floor of her parents' home the day after he died. As with Van Gogh, prices for Modigliani's works were trivial during his lifetime, but are counted in the millions of dollars today. Two days after his death, prices for his paintings increased by 10 times the prices achieved during his lifetime. Ten years later the prices were up over 3,000 times. In 1984, *La Reveuse*, a nude shown against a dark background, sold at Sotheby's for \$4.6 million. In 1989, *La Belle Romaine* was auctioned for \$7.2 million. This set a record for Modigliani and for any painting sold in France. Modigliani's native city of Livorno, Italy, dredged a canal in 1984, in search for sculpture the artist may have discarded.

Art and Culture

According to legend, when Modigliani left Livorno for Paris, there was no market for his works. He threw the remains of his studio into the waters of the canal. Unfortunately for Livorno, no Modigliani originals were found in the dredging.

Both Van Gogh and Modigliani are highly esteemed today by collectors and critics, although few people admired the production of either artist during their lifetimes. They died at approximately the same ages. Van Gogh did not mix well with other people and was hardly handsome. Modigliani, in contrast, was suave, charming and good looking.

Modigliani's unique style of painting is seen in his portrait of the art dealer and author Paul Guillaume. The oil paint was used very thinly, similar to watercolor. The colors are predominately earth tones. Although some have suggested that the elongated forms of Modigliani's art could have been due to an ocular defect (astigmatism), there is no data to support such a conjecture. The artist admired the elongation of Italian primitive art and of icons. He was influenced by the sculptor Brancusi, who brought him in contact with the vertically elongated shapes of African sculpture.

The portrait of Guillaume is characteristic of Modigliani. The subject is not beautified, but is treated sympathetically. He looks tired and sad. The head is tilted, the eyes are almond shaped, the neck is overly long, and the shoulders are rounded. Modigliani has turned Italian primitivism into a sophisticated 20th century work. Similar to the production of Van Gogh, it is far better appreciated today than when it was created. **OSMA**

Modigliani. Paul Guillaume. Oil on board, 1915. 29 1/2 x 20 1/2 inches. Toledo Museum of Art.



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Obituaries

JULIUS J. BOLDIZAR, MD, Northfield; St. Louis University School of Medicine, St. Louis, MO, 1924; age 94; died October 7, 1991; member OSMA and AMA.

EDGAR A. FRY, MD, Columbus; Ohio State University College of Medicine, 1932; age 84; died September 12, 1991; member OSMA and AMA.

MIKELIS GEISTAUTS, MD, Bothell, WA; Latvijas Universitate Medicinas Fakultate, Riga, Latvia, 1936; age 88; died January 2, 1991; member OSMA and AMA.

WILLIAM HALLARAN, MD, Cleveland; Case Western Reserve University School of Medicine, 1932; age 87; died September 18, 1991; member OSMA and AMA.

CLARENCE J. PODORE, MD, Cincinnati; University of Illinois at Chicago Health Sciences Center

Chicago, IL, 1945; age 68; died October 5, 1991, member OSMA.

CLARK P. PRITCHETT, MD, Columbus; Ohio State University College of Medicine, 1934; age 83; died September 23, 1991; member OSMA and AMA.

SALAH M. RABAA, MD, Canton; Faculty of Medicine Damascus University, Damascus, Syria, 1965; age 52; died September 20, 1991; member OSMA and AMA.

VERNERS RUTENBERGS, SR., MD, Cleveland; Latvijas Universitate Medicinas Fakultate, Riga, Latvia, 1929; age 92; died August 28, 1991; member OSMA and AMA.

ANTANAS SAVICIUNAS, MD, Akron; Vytauta Didziojo University Medical Fakulteto, Kaunas, Lithuania, 1935; age 82;

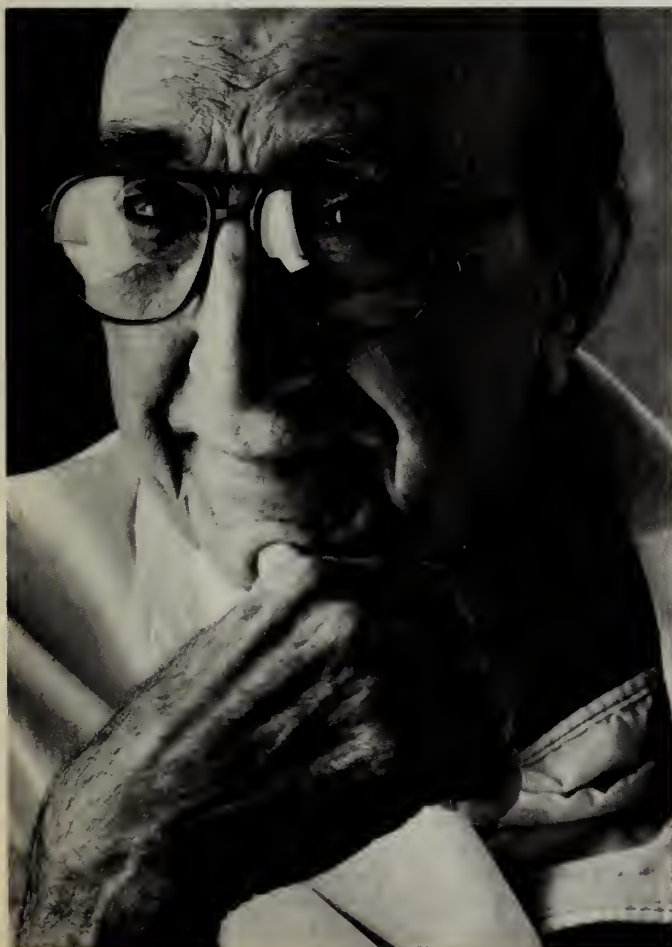
died September 11, 1991; member OSMA and AMA.

JAMES A. SCHAAL, MD, Cincinnati; University of Cincinnati College of Medicine, 1934; age 86; died September 18, 1991; member OSMA and AMA.

EMIL STEINER, MD, Cleveland; University of Cincinnati College of Medicine, 1933; age 85; died September 24, 1991; member OSMA and AMA.

LEWIS URLING, JR., MD, Lancaster; University of Pittsburgh School of Medicine, Pittsburgh, PA, 1950; age 67; died September 14, 1991; member OSMA.

FREDRICH URSCHLER, MD, New Port Richey, FL; Universitaet Graz, Medizinische Fakultate, Graz, Austria, 1952; age 63; died June 5, 1991; member OSMA.



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Ohio Medi-Scene

New display touts "replacement" medicine

The Center of Science and Industry in Columbus is hosting a new traveling exhibit that is bound to interest those in the medical profession.

"Bionics and Transplants: The World of Replacement Medicine" bowed in at COSI in late September and will be on display there through January 5, 1992.

The exhibit, according to COSI spokesperson Heather Weigand, "contrasts popular notions of bionics with real accomplishments of today's surgeons and biomedical engineers." It's divided into sections which correspond to major body systems, like hearing and movement, or to technologies, like organ transplantation and reconstructive surgery.

COSI is located at 280 E. Broad Street in Columbus, for those who'd like to pay a visit and see the exhibit for themselves. **OSMA**

UC starts "wellness" experiment

Sixty-one students at the University of Cincinnati have volunteered to be the first residents of a new "wellness" floor in UC's Daniels Hall, where the emphasis will be on healthy eating, plenty of rest and proper exercise. "The primary focus is going to be personal health, no smoking, no drinking, and things that are alien to most college kids," says Marcus McGhee, the floor's residential adviser. All the students have signed contracts pledging to abstain from alcohol and drugs.

Instead, they will take part in



semi-weekly aerobics and fitness programs at the school's weight center, participate in workshops that teach them how to reduce stress, manage their time and resolve conflicts, and keep a dietary journal in which they write down what they eat. "Studies have shown incoming (first-year students) don't eat right," says Melinda Piles, the university's program coordinator for campus wellness. "They're often putting on 10 to 15 pounds when they come to school."

The volunteer students, most of whom are first-year females, will be tracked to see if their grades and failure rates are lower than other incoming first-year students, or whether there is some connection to the sound body, sound mind theory. **OSMA**

Columbus cancer hospital ranks sixth nationally

A team of internationally recognized oncology physicians and researchers have included the Arthur G. James Cancer Hospital and Research Institute in Columbus among the top 100 cancer treatment centers in the country, placing it sixth on their list.

The "top 100" list, the first of what is to become an annual feature in the magazine *Coping*, represents treatment centers that are recognized regionally or nationally for their exceptional care and treatment of cancer patients.

Since its opening in July 1990, the James Cancer Hospital has served more than 3,100 inpatients and 21,000 outpatients. **OSMA**

Cincinnati develops as research center

Cincinnati may soon become a major research location if two facilities earmarked for the area open as promised.

Procter & Gamble Co. was the first to unveil its plans for a \$280 million health-care research center in Warren County, consolidating current research facilities now spread from New York to Japan.

Then, Marion Merrell Dow, Inc. revealed that it will establish a center for cardiovascular research and education at the University of Cincinnati Medical Center.

UC is among many research centers turning to industry for funding — an alliance that is welcomed by the National Institutes of Health, which believes that industry can help provide the funding for research that the government cannot afford. **OSMA**

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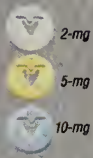
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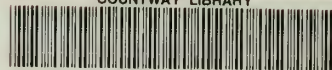
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